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ABSTRACT

Addressing American Indians and the Indian Health Service (IHS), this report focuses on the process of Indian involvement and self-determination in health, emphasizing improvement of the effectiveness and responsiveness of Indian health services. Data derived from written documents, statistical figures, and personal interviews with over 200 people (tribal leaders, health board members, service unit directors, etc.) is presented via a 3 chapter focus. The 1st chapter details IHS structure and operational procedure (history, background, and goals; organizational structure and administration; relationship to the Department of Health, Education, and Welfare; decision-making authority; planning and priorities; budgeting; staffing; and training programs). The 2nd chapter deals with Indian involvement (evolution of policy; responsibility for Indian involvement in IHS; Indian health boards; contracting with tribes and health boards; community health representatives; tribal health departments; and cultural sensitivity in IHS). Specific IHS issues constitute the focus of the final chapter (level of Indian health; health benefit package; the outpatient clinic; alcoholism; contract care services; 3rd party resources; national health insurance; and health maintenance organizations). (JC)

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A STUDY OF THE INDIAN HEALTH SERVICE AND INDIAN TRIBAL INVOLVEMENT IN HEALTH

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*The principals of Urban Associates, Inc. are now operating under Rj Associates, Inc.

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INTRODUCTION

This study of the U.S. Indian Health Service (IHS) is one of a series of reports being developed by Urban Associates, Inc., (UAI) under Contract No. HEW OS-72-209 with the Office of Special Concerns, Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary, U.S. Department of Health, Education and Welfare.

The basic purpose of the contract was to conduct a two-phased, comprehensive study of major barriers to culturally-relevant delivery of DHEW services to the three major ethnic minority groups in America today: Spanish Speaking, Asian Americans, and American Indians.

This IHS study was undertaken as part of Phase II. In its Phase I report, Urban Associates presented profiles of the three ethnic minorities and major subgroups; analyzed nine selected types of DHEW-funded programs; compiled findings on problems in the delivery of HEW services to ethnic minorities in such areas as the HEW accountability system, data collection, guideline development, and allocation of funds; and discussed the implications of the initial study. For Phase II, in addition to this report on the Indian Health Service, UAI will also issue separate reports on:

- A study of ethnic minorities in health manpower.
- Separate analyses of 1970 Census data on ethnic minorities--American Indians, Asain Americans, and Americans of Spanish origin.
- A study of the impact of DHEW decentralization on the ethnic minorities
- A field study to determine the extent to which DHEW services are responsive to the needs of Asian Americans

The Indian Health Service Study

HEW authorized the preparation of this study shortly after the Indian Trail of Tears in October and November of 1972. Based on the issues raised by the participants in the Trail of Tears and the White House Task Force that grew out of it, HEW felt it had an obligation to the Indian people to initiate a reassessment of its policies and procedures towards Indians. As part of that reassessment, the agency mandated the Office of Special Concerns (OSC) to include a component on the Indian Health Service, the agency's largest Indian program, in the Phase II Study on Ethnic Minorities that OSC was developing with UAI.

The Office of Special Concerns represents the concerns of ethnic minorities (American Indians, Asian Americans, Spanish Surnamed, Blacks, and Women) in HEW. The office of American Indian Affairs 1/ in OSC recognized that the standard format for an evaluation, in which the agency determines the issues to be studied, would not provide the kind of study being sought by HEW. It therefore asked UAI to do a preassessment analysis to determine the issues Indians identified as their areas of concern in regard to health services.

In conducting the preassessment, we interviewed many Indians and IHS staff throughout the country. They indicated that a significant change is taking place in the relationship between Indians and IHS. In the past the relationship has tended to be one-way--an active provider and a passive consumer. Indians have felt alien to the system of health care--they have not had sufficient information to understand how IHS works, how to impact the system, or what mechanisms are available to them to improve their bargaining position. Also they have been so immersed in trying to deal with the Bureau of Indian Affairs (BIA), that they have not had the time to direct attention to IHS, particularly since IHS has generally been a much more competent and concerned agency than the BIA.

Our interviews among IHS staff indicated that until recently, Indians tended to accept this alienation. Of late, however, Indian tribes have begun to push aggressively for the right of self-determination. In the past, when dissatisfied they would ask, "How can we get IHS to change things?" Now they ask, "How can we change things?" They want to know, "What is IHS, how does it work; and where and how do we as Indians fit into this system and make it responsive to us?"

Therefore, while Indians raised the same issues with our staff that they have recited repeatedly to the Civil Rights Commission, Congress, and in numerous other surveys--complaints of long waiting lines in the clinics, mistreatment in contract care facilities, lack of transportation, and the like--there also emerged certain overriding general concerns about the health care system that go beyond specific complaints about services. The three primary needs expressed were:

(1) The need to have more knowledge about IHS and how it works in order to effect positive change within the agency.

(2) The need to develop their own mechanisms or institutions, such as health boards and tribal health departments that can exercise power in relation to IHS, and health care delivery institutions in general, in order to make services to Indians more effective and more culturally sensitive.

1/ Since the start of the study OAIA has been transferred to the Office of Native American Programs in the Office of Human Development/HEW

(3) The need for a more thorough understanding of current relevant health issues such as National Health Insurance and Health Maintenance Organizations, and alternative health care delivery systems (not necessarily involving knowledge of medical techniques), so that they can choose intelligently among the options available to them for dealing with their specific health services delivery problems.

These general concerns are not brand new; the Indian community has not been operating in a vacuum in its relationship to IHS. In recent years IHS has initiated a broad-ranging program to assist Indians to increase their involvement in shaping their health delivery system. While IHS has just initiated this program to help tribes in the process of self-determination, that program is more committed and creative than that of any other federal agency.

Based on these interviews, it was concluded that to examine health services for Indians is to look at two faces of a coin: the Indian Health Service and the Indians. Both must play a role in bringing about change and improvement in health care for Indians and they have begun to do so. Accordingly the intended audience of this report is both Indians and IHS; a report addressed solely to IHS or HEW would be ignoring one-half of the participants. The focus of this report is the process of Indian involvement and Indian self-determination in health, the issue both Indians and IHS considered to be the single most important factor in improving the effectiveness and responsiveness of health services to Indians.

Interwoven throughout the report as we respond to the needs of Indians, are discussions of how certain aspects of the IHS system make it more difficult for Indians to impact the system or use the mechanisms for Indian involvement. In such cases, recommendations are made for changes by IHS that could alleviate some of these difficulties. Most of the alternative approaches suggested in regard to these specific health problems are not new or theoretical ideas, but come from developmental work being done by IHS units and tribes visited during our field interviews. We found that IHS was aware of most of these problems and was searching for new ways of dealing with them. Many of the new approaches have not been communicated to tribal health leaders or to IHS staff who indicated a strong desire to know more about them.

The report does not have a separate section on recommendations. We believe that an isolated section advising IHS or tribes what they should do is incompatible with the concept of self-determination. The report does contain alternative approaches, options, and some suggestions. However, in all cases they are integrated into the section at issue. Self-determination is a dynamic process. The process of developing the strategies and approaches is as important as the results themselves if meaningful change is to occur. This

report is intended to be used as part of that process. The alternatives and options are intended to serve the same function as the rest of the discussion of which they are a part; to provide a take-off point for thinking, and adaptation by tribes and Indian groups so that they can ultimately develop their own models that will be uniquely responsive to their local needs.

Limitations on the Scope of the Study

Because no report can adequately cover all issues involving Indian health, several different criteria were applied in determining what specific issues would be discussed in the report or in any given section. First, no "medical" topics as such are discussed, e.g., different ways to treat gastroenteritis or cirrhosis, since that was not the purpose of the study. Reference is made in the report to unique and apparently successful methods of treatment of various diseases being developed by the Office of Research and Development at the Health Programs System Center (HPSC) in Tucson. Reports of these research projects, which are available from HPSC, offer some exciting options in the treatment of different diseases, including a heavy commitment to the expanded use of Indian paramedical personnel.

Also, we do not discuss those areas of concern that are presently or soon to be under study by other groups. For example, IHS's mental health program is presently undergoing a comprehensive evaluation by the Harvard Department of Psychology and the Association of American Indian Social Workers. The National Indian Health Board (NIHB) has indicated that it intends to evaluate IHS's Environmental Health and Sanitation Program and the status of IHS facilities. Therefore these issues are only referenced.

The study does not discuss the health problems of Indians living in urban areas. Urban Indians have severe problems in obtaining health services that they can afford and that are responsive to their Indian perspectives on health. They are denied services by urban health providers on the grounds that "they are the responsibility of IHS." This is untrue both legally and practically. Indians, urban or otherwise, have the same rights to federal, state, and local health services as have any other citizens. Also IHS does not have facilities in urban areas to "take responsibility" for them. Until recently the primary question was whether IHS (or the BIA) had the legal authority and responsibility to serve Indians not living on reservations. However, the Director of IHS has fully acknowledged IHS's legal authority to serve them. Also a recent Supreme Court case (Ruiz v. Morton) has held that the BIA (and thus by reference the IHS) has a legal obligation to serve Indians living "near" reservations as well as those living on them. While the Court limited its holding to near-reservation Indians and did not expand it to cover all Indians living off the reservations, the case breaks significant new ground in this regard.

In addition to the question of legal authority, IHS has not been given the necessary funding to provide services to urban Indians. However, over the last few years, IHS has provided funds

for development (not delivery) of services to a number of urban and off-reservation Indian health projects. There are now a number of excellent models of such programs operating throughout the country: the California Rural Indian Health Board, the Minneapolis Urban Health Program, the Seattle Indian Health Board, the California Urban Indian Health Committee, and others. Much more needs to be done.

However, it was concluded that within the resources available to this report, it would be impossible to do a comprehensive study of both reservation and urban Indian health programs. As we started into the research on the study we began to discover the vast number of unique programs being developed by Indian tribes and the tremendous diversity of the Indian Health Service program as one moved from Area Office to Area Office, and Service Unit to Service Unit. We realized that it would be impossible to get an accurate picture and draw useful observations if we divided our time between tribal programs and urban programs. As a result, we opted to focus the report completely on health programs on reservations.

In reaching this conclusion, we did not intend in any way to minimize the problems of urban Indians. From the few visits we made to urban Indian health programs, there was evidence that with some funds and technical assistance, significant accomplishments could be achieved to improve their health services. We strongly recommend that HEW provide the resources for a separate study that concentrates on the problems and potentials of health services delivery to Indians living in urban areas.

Research Approach

A broad range of resources was tapped to obtain the information used in the writing of this report. Urban Associates staff conducted interviews with approximately 200 persons, culled numerous written documents, and analyzed a variety of statistical information.

For the on-site interviews, our staff attempted to contact as wide a cross-section as possible of the persons and institutions involved with Indian health. (The list of persons interviewed appears in Appendix A.) We visited and conducted on-site interviews at the National Indian Health Board, IHS Headquarters, four IHS Area Offices and their Health Boards, The IHS Office of Research and Development, ten tribes and IHS Service Units, various experimental Indian health programs, and numerous Indian organizations.

Each of the some 250 tribes in the United States is developing its own approach to Indian self-determination in the area of health. Each has a different relationship with IHS and a different approach

for increasing its involvement in the provision of health services to its people. Similarly, each Service Unit (the IHS reservation-level delivery unit for health care), is developing its own unique relationship with the tribe it serves. The tribes and Service Units visited were selected for this study on the basis that each was at a different place in the spectrum of possible tribal-IHS relationships: a tribe with a strong Health Board, a weak Health Board, a tribal health department, a tribe involved in an intertribal health management arrangement, an active Service Unit Director, a Service Unit Director uninterested in community involvement, a tribe with an effective CHR program, a Service Unit with an innovative Family Doctor Program, etc. By examining these experiences, we were able to obtain some valuable information on the processes of IHS management and Indian-IHS involvement. But because of the uniqueness of the tribes and the Service Units, we also recognized the dangers of trying to develop too broad generalizations from these experiences.

The tribes visited were the Northern Cheyenne and Crow in the Plains area; Indian groups in and around Seattle in the Northwest; Navajo, Papago, Gila River, White Mountain Apache, and Hopi in the Southwest; and Seminole, Choctaw, and Miccosukees in the Southeast. At these sites, interviews were conducted with tribal leaders, Health Board members, Service Unit Directors (SUD's), CHR coordinators, traditional medicine practitioners, consumers, tribal health staff, and physicians, as well as with a broad range of IHS staff members, both Indian and non-Indian.

The Indian Health Service has decentralized substantial authority to its eight Area Offices. As a result, each Area Office has a different structure, different priorities and different relationships with both its Service Units and the tribes it serves. Our original contract called for field visits to three Area Offices. However, because there is no "typical" Area Office, any more than there is a "typical" tribe, and in order to be as sensitive as possible to the variety of Area Office systems, field visits were made to four of the eight Area Offices, again with an effort to get the best cross-section possible within the time and resources allocated for this study. Interviews were conducted at the following: Billings (Montana) Area Office, a small Area and one of the two in the Northern Plains; Portland (Oregon) Area Office, which is unique in that there are no IHS hospitals in the Area and all inpatient care and half of the outpatient care is provided through private hospitals and physicians; Phoenix Area Office, one of the large Southwest Areas, with a large Regional Indian Medical Center at its nucleus; and the Navajo Area Office, which serves one tribe only, the Navajos, who represent about 20% of the entire IHS service population. A field visit was also made to the Tucson Program Area, which oversees the major IHS training center, Desert Willow Training Center, as well as the Health Programs System Center (HPSC), the IHS research and development office.

At the Area Offices, interviews were concentrated on officials concerned with the IHS management system and with Indian

involvement, including: Area Directors; EEO and Training Officers; heads of Offices of Planning and Evaluation, Fiscal Management, Contract and Contract Health Services, Tribal Affairs and Indian Community Development, and Mental Health; and the branch chiefs of several of the hospital and field medical branches. Members of the Area Indian Health Board for each Area visited were also interviewed.

Field trips were also made to several unique, experimental Indian health programs, including United Southeastern Tribes (USET), where USET staff, IHS employees, and Indian Board members were interviewed; the Navajo Health Authority, and the Seattle Indian Health Board, at which interviews were held with providers, staff board members, and consumers.

A variety of Indian organizations connected with health were also contacted as part of the study. These included members, staff, and consultants of the National Indian Health Board (NIHB), the National Indian Training and Research Center (NITRC), the Center on Indian Alcoholism and Drug Abuse, and several Indian consulting firms that have held contracts with the IHS, as well as the major national Indian organizations including: The National Congress of American Indians, National Tribal Chairmen's Association, Americans for Indian Opportunity, and the Institute for the Development of Indian Law.

At IHS Headquarters in Washington, interviews were conducted with the IHS Director, Deputy Director, the directors of the four IHS Headquarters Divisions, the Assistant General Council for HSA, and a large number of IHS Headquarters staff in a variety of offices, particularly Planning and Evaluation, Program Statistics, and Strategic Planning.

Finally, we interviewed the staffs of the various Congressional committees dealing with Indian health and with National Health Insurance proposals. We received consultation on Health Maintenance Organizations (HMO's) from executives at the Georgetown University Community Health Plan and information on a variety of health issues from the Health Law Institute at the University of Pennsylvania.

Lastly, statistical analysis was done on the level of Indian health (mortality and morbidity), utilization of IHS facilities by Indians, and staff patterns within IHS. Statistical data were obtained from the IHS Office of Program Statistics, HEW's Center for Vital Statistics, the Canadian Provinces' Health Departments, and the health departments of 15 states with significant Indian populations. For the analysis of IHS staff patterns, a special computer run was done by HEW on IHS employees, broken down by Area Office and Service Unit. Data were also obtained from the University of Arizona Regional Health Center on the health status of Arizona Indians.

During the field investigations, Urban Associates staff spent hundreds of hours talking to almost 200 people involved with and concerned about Indian health, sometimes necessarily at late hours or in the middle of busy work schedules. In every case, people were cooperative, informative, candid, and friendly. Such attitudes made a long task stimulating and enjoyable, and we are greatly appreciative to these individuals.

Organization of the Report

The report is organized into three chapters. Chapter I begins by providing a brief outline of the history, goals, and structure of IHS, and a short review of the present level of Indian health--the progress made since 1955 when IHS first came into being, and the problems still facing them in the future. In following sections, it reviews in detail the structure and management of the Indian Health Service, including how IHS makes its management and budget decisions, sets priorities, plans, staffs, provides training, and relates to HEW and other federal agencies. In certain cases, the report finds that the present system, inherited by IHS or adopted voluntarily, has problems that frequently serve to make it harder for Indians to impact the system. In such cases, recommendations are made that could improve the system without altering the flexible and human qualities that IHS has successfully integrated into a bureaucratic structure.

Chapter II discusses the process of Indian involvement. It is a two-sided process requiring the development of new structures and new relationships by both IHS and the tribes. The chapter first reviews the administrative system being used by IHS to foster Indian involvement. It then examines the various mechanisms being developed by tribes to increase their policy and/or operational control over their health services. There are separate sections on Health Boards, tribal health departments and authorities and the contracting of tribal programs by tribes, including a review of the Community Health Representative Program as a case study of the contracting process. Both Indians and the IHS staff felt there were a number of deficiencies in the present efforts to bring about Indian involvement, and some alternative approaches are suggested for improving the system. Since one of the objectives of increased Indian involvement is to make the health system more culturally sensitive to Indians, there is also a section on cultural sensitivity as it relates to health services.

Chapter III discusses specific health delivery issues which Indians have indicated are areas of concern. The first section discusses the level of Indian health and the structure and utilization of IHS health services by Indians. It then examines specific issues of concern: such as clinic waiting lines and

contract care. For each of these issues the report describes how the present system works and then discusses some experiments or alternative approaches that have been used, either by IHS or in other health delivery systems, to correct the problems. The list of options is not intended to be exhaustive, but rather to indicate that the system is not inflexible and that successful alternatives have already been implemented to deal with them in at least some places, under certain conditions.

Chapter III also discusses two of the most prominent new developme in health--National Health Insurance and Health Maintenance Organizations. The section on National Health Insurance reviews the impact of the program on Indians and offers several alternative approaches Indians could use to insure that they obtain maximum benefit from it. The section on HMO's describes what HMO's are and how they work, and discusses their possible usefulness to Indian tribes seeking to assume operational control of their health delivery system.

Our orientation throughout has been to avoid simplistic solutions. There is no grand design for "solving" the problems of Indian health. Even for a specific problem there is no one approach that will be appropriate to all tribes.

Our commitment is to the concept of self-determination through the mutual efforts of Indian tribes and the Indian Health Service. One of the Indian leaders interviewed for this study spoke of the day when he hoped to see two health structures on Indian reservations--one tribal and one IHS--two buildings side by side and equal in size, expertise, and dignity. The structures would be working together closely and in harmony so that a person could move from one to the other without really noticing a change. Together they would be providing high quality, culturally sensitive services to Indian people. Dr. Emery Johnson, Director of the Indian Health Service, reported that his goal was a single integrated system, part Indian-part IHS, so interwoven that one could not determine where the role of IHS ended and that of the Indian health organizations began. Either way, Indian tribes and IHS are not working towards that goal. This report is directed towards assisting in the achievement of that goal.

I. INDIAN HEALTH SERVICE

STRUCTURE AND OPERATIONS

I. INDIAN HEALTH SERVICE STRUCTURE AND OPERATIONS

A. BACKGROUND/IHS GOALS

It has been stated that the pre-Columbian Indian was virtually disease free. 1/ But with the coming of the European settlers the advent of human disease began to take its toll. 2/ The federal government first began providing health services to Indians during the early reservation days (the early 1800's). At times the services were provided to fulfill treaty promises made by the government in return for taking Indian land. More often it was provided to stop epidemics among Indians before they endangered U.S. soldiers stationed in Indian country.

Federal health services to Indians grew unevenly. For a long period Indian health activities were financed from miscellaneous funds appropriated to the BIA. Appropriations earmarked specifically for health services to Indians began with $40,000 in 1911. The Snyder Act of 1921 3/ provided the formal legislative authorization for health services to Indians. It authorized the Secretary of the Interior to expend funds for the "relief of distress and conservation of the health of Indians." This short phrase in the Snyder Act continues to be the basic legislative statement on the federal government's obligation to provide health services to Indians.

Original responsibility for services was placed in the Bureau of Indian Affairs in the Department of the Interior. The BIA built and ran hospitals and clinics and provided other health services. However, the program was continually plagued with problems, including severe understaffing and inadequate appropriations. By the mid-1940's, health services and the level of Indian health had deteriorated so severely that pressure began to mount for the transfer of the Indian health program to the Public Health Service in HEW. The initial impetus for the transfer came from several studies done of the BIA health program, including a 1948 Bureau of the Budget study, the 1949 report of the Hoover Commission, and a 1949 study by the American Medical Association,

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1/ U.S. Public Health Service, "Observations on Indian Health Problems and Facilities," by Townsend, Bulletin No. 223, 1936.

2/ Office of Special Concerns, HEW, "Issues Paper on the Indian Health Service," by D. Sakiestewa, 1973.

3/ 42 Stat 208.

all of which found the need for a new approach to Indian health problems. 1/ The arguments in favor of transfer included:

- PHS was more attractive to health professionals; therefore putting IHS under PHS could help ease the staffing problems encountered by the BIA.
- Within PHS, Indian health services would be under direct medical supervision, which was not the case in the BIA, where the supervision lay with agency superintendents and others who were not medical professionals.
- PHS, with its medical expertise, would be better able to explain its budget requests to Congress and thereby obtain more adequate appropriations than the BIA was able to obtain.
- Also it was thought that the transfer would hopefully enable the resources of the entire HEW health system to be made available to Indian health problems. 2/

In 1954, Congressmen advocating termination saw the transfer of health services to HEW as being in line with their effort to repeal laws that set Indians apart from other citizens. 3/

Thus, the incongruous coalition of those advocating termination of reservation status and those advocating improved health services to Indians pushed through the Transfer Act 4/ and in 1955 federal responsibility for health services to Indians was transferred to the newly created Division of Indian Health, under the U.S. Surgeon General in the Public Health Service, HEW. Since 1955 the Division of Indian Health has been retitled the Indian Health Service (IHS). The functions of the Surgeon General have now been abolished, and the health service programs in HEW have gone through several administrative reorganizations. IHS is now a division of the Public Health Service in the Health Services Administration (HSA) of HEW. 5/ Despite its inception in a termination atmosphere, IHS has grown rapidly since 1955. From a budget of $34.5 million and a staff of 2,900 in 1955, it now has a staff of 7,400, and an annual budget of approximately $200 million.

The goal of the Indian Health Service is "to elevate the health status of the Indian people to the highest possible level." Its mission is "to assure the availability of a comprehensive health service delivery system that will provide Indians and

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1/ U.S. Senate, Committee on Interior and Insular Affairs, "Report on the Transfer Act," June 1954, p. 8.

2/ U.S. Surgeon General, HEW, "Report on Indian Health," 1957.

3/ U.S. Senate, Committee on Interior and Insular Affairs, op. cit., p. 2.

4/ 71 Stat 370 August 5, 1954.

5/ HSA is one of the four major program divisions of HEW along with the Office of Education, Social and Rehabilitative Services, and the Social Security Administration.

Alaska Natives opportunities for maximum involvement in defining and meeting their own health needs." To achieve its goal and accomplish its mission, IHS has developed three major program objectives:

(1) To develop and apply modern innovative approaches and methods to effective, responsive and high quality health services delivery systems, which are amenable to local direction and manning by Indians in accordance with their stated wishes;

(2) To acquaint Indian people with available health programs for which they, as American citizens, are eligible, to encourage their participation in such programs, and to alert health program administrators to Indian needs, and ways in which such needs can be met;

(3) To be responsive to the desires of Indians to engage in the self-determination process by providing options for them to manage and otherwise guide and participate in the planning, operation and evaluation of Indian Health Service health services delivery systems. 1/

To carry out its program, the Indian Health Service has established three administrative levels: Headquarters, Area Offices and Service Units. Headquarters is located in Rockville, Maryland. The eight Area Offices (AO's) correspond roughly, in function, to HEW Regional Offices. However, to be closer to the IHS service population, their locations most nearly correspond to the BIA Area Offices (out of which they emerged in 1955) rather than to the locations of the HEW regional offices. The 86 Service Units (SU's) are the primary health delivery units in IHS. They are located on Indian reservations, in cities in which IHS has regional medical centers and in non-reservation areas, particularly in Oklahoma and Alaska, where there are concentrations of Indians who are part of the IHS service population.

IHS estimates that its service population is about 488,000 Indians and Alaska Natives. 2/

1/ Dr. Emery Johnson, Director of IHS.

2/ Throughout this report the term "Indian" is used to include both Indians and Alaska Natives.

I. B. IHS ORGANIZATIONAL STRUCTURE AND ADMINISTRATION

The basic structure and administration of the Indian Health Service is of great importance to the kind of health care that is delivered to Indians throughout the country. This section describes the agency and its relationship to its parent organization, HEW; discusses IHS Area Offices, Service Units, and the recent policy of decentralization; and administrative aspects of IHS such as the decision-making process, budget, planning, priorities, staffing, and training.

Indian Health Service carries out its program through its Headquarters office, eight Area Offices (AO's) (which parallel the Bureau of Indian Affairs Area Offices, rather than the HEW regional offices), and 86 local Service Units (SU's), located primarily on reservations in 24 states. Indian Health Boards are organized, in most cases, to parallel the IHS structure.

1. Headquarters

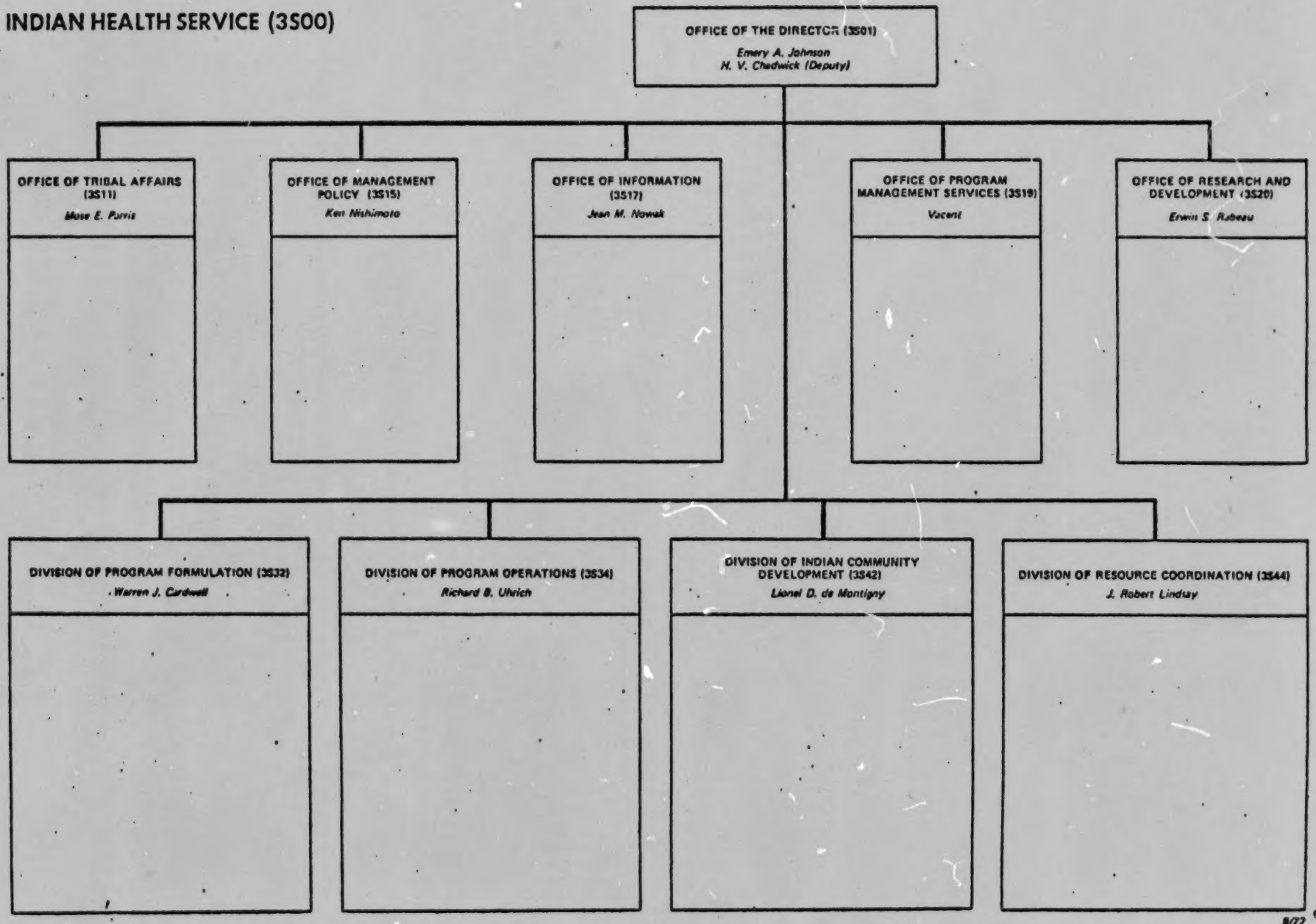
Headquarters consists of the Office of the Director, the Deputy Director, five support offices (to provide staff resources to the Director), and four operating divisions. The five support units are: Office of Management Policy, Office of Tribal Affairs, Office of Information, Office of Program Management Services (which includes Administrative Services and Financial Management), and Office of Research and Development (ORD) located in Tucson. The four operating divisions are: Division of Program Formulation, Division of Program Operations, Division of Community Development, and Division of Resource Coordination (see IHS Organizational Chart on following page). 1/

The Division of Program Formulation performs strategic and long-range planning for IHS. In addition to developing the philosophical concepts on which IHS policy is developed, it reviews legislative activity that may affect Indian health, and is responsible for policy assessment and special studies. This division defines how IHS can achieve its long-range goals. It is considering such issues as the effects of National Health Insurance on Indians; where malpractice insurance can be obtained if an Indian tribe takes over the IHS services; and who would set health and hospital standards for an Indian-run health delivery system.

Keeping the IHS administrative system moving and functioning is the responsibility of the Division of Program Operations. It is the primary, day-to-day link between Headquarters and Area Directors, funneling information and complaints in both directions and monitoring the Area Offices to insure that their programs are operating within the broad parameters set by Headquarters.

1/ This organizational structure (see pg. 6) was in effect at the time our report was originally prepared. Since that time a reorganization has occurred which is reflected in the Chart on page 6-a.

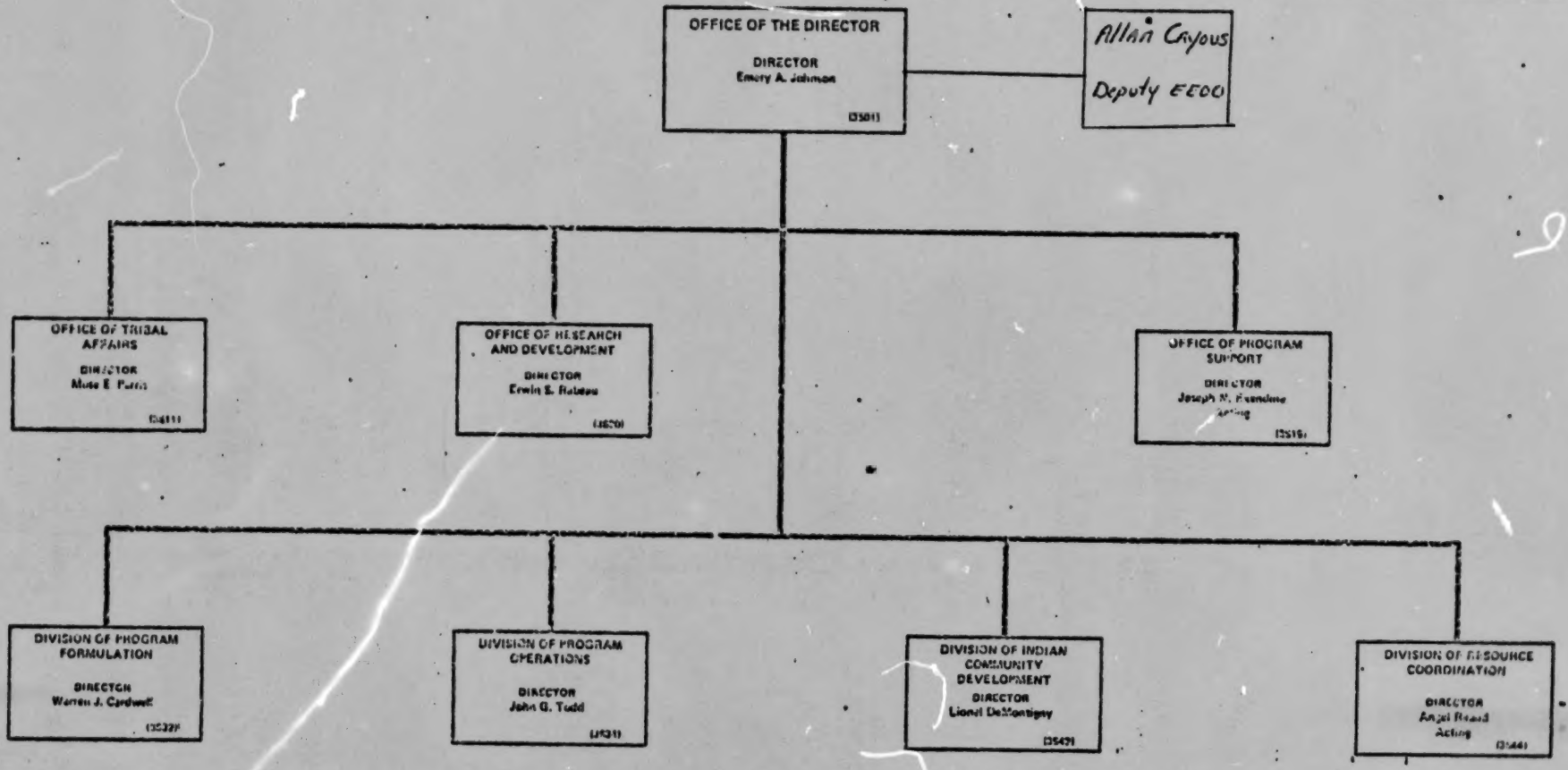
INDIAN HEALTH SERVICE (3S00)


OFFICE OF THE DIRECTOR (3S01)
Emery A. Johnson
H. V. Chadwick (Deputy)
OFFICE OF TRIBAL AFFAIRS (3S11)
Mose E. Parris
OFFICE OF MANAGEMENT POLICY (3S15)
Ken Nishimoto
OFFICE OF INFORMATION (3S17)
Jean M. Nowak
OFFICE OF PROGRAM MANAGEMENT SERVICES (3S19)
Vacant
OFFICE OF RESEARCH AND DEVELOPMENT (3S20)
Erwin S. Rabeau
DIVISION OF PROGRAM FORMULATION (3S32)
Warren J. Cardwell
DIVISION OF PROGRAM OPERATIONS (3S34)
Richard B. Uhrich
DIVISION OF INDIAN COMMUNITY DEVELOPMENT (3S42)
Lionel D. de Montigny
DIVISION OF RESOURCE COORDINATION (3S44)
J. Robert Lindsay

0021

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
Health Services Administration
INDIAN HEALTH SERVICE

APPROVED:
DATE: 6-30-74
APPROVED:
DATE: 6-30-74



0022

The Division of Community Development has primary responsibility for promoting Indian involvement in IHS and developing Indian capacity for delivering health services. The Division, which has no counterpart in most AO's, usually works directly with tribes or Indian groups helping them develop health departments and consumer evaluation programs, and assisting Indians living in urban areas to develop urban Indian health programs.

By far the largest of the four divisions is the Division of Resource Coordination. Its branches parallel those found in the Area Offices--medical, dental, nursing, contract health services, planning and evaluation, etc. The branches provide technical assistance and guidance to their respective branches in the Area Offices. In addition, this Division provides liaison with other HEW health programs and does the operational planning and evaluation for IHS.

An IHS Headquarters executive committee, made up of the Director, the Deputy, the heads of the four divisions, and other resource people, meets several times a week to discuss a broad range of matters, from pressing issues to long-range concerns. In addition, IHS has established a program advisory committee (PAC) consisting of the Director and Deputy Director of IHS, the eight Area Directors, and the members of the National Indian Health Board. The PAC meets regularly to assist the Director to develop general policy for IHS. Subcommittees of the PAC have been formed to deal with specific problems, such as new methods of allocating contract care funds and the effects of National Health Insurance on Indians.

2. Area Offices

The eight IHS Area Offices (Aberdeen, Alaska, Albuquerque, Billings, Navajo, Oklahoma, Portland and Phoenix), have no typical or standard structure. IHS has delegated extensive authority to the Area Offices, each of which is free to develop the structure that meets its needs and orientation (see Tables I-B-1, -2, -3). Usually an AO has an Office of the Area Director, and offices for the following functions: financial management, program planning and evaluation, equal employment opportunity, tribal affairs and/or community development, personnel, contracts, and environmental health. In addition, there are health services offices or branches that work with the various health service programs at the delivery level: medical, nursing, mental health, pharmacy, health education, nutrition, social services, dentistry, and others.

Table I-B-1

NAVAJO AREA INDIAN HEALTH SERVICE

ORGANIZATIONAL CHART

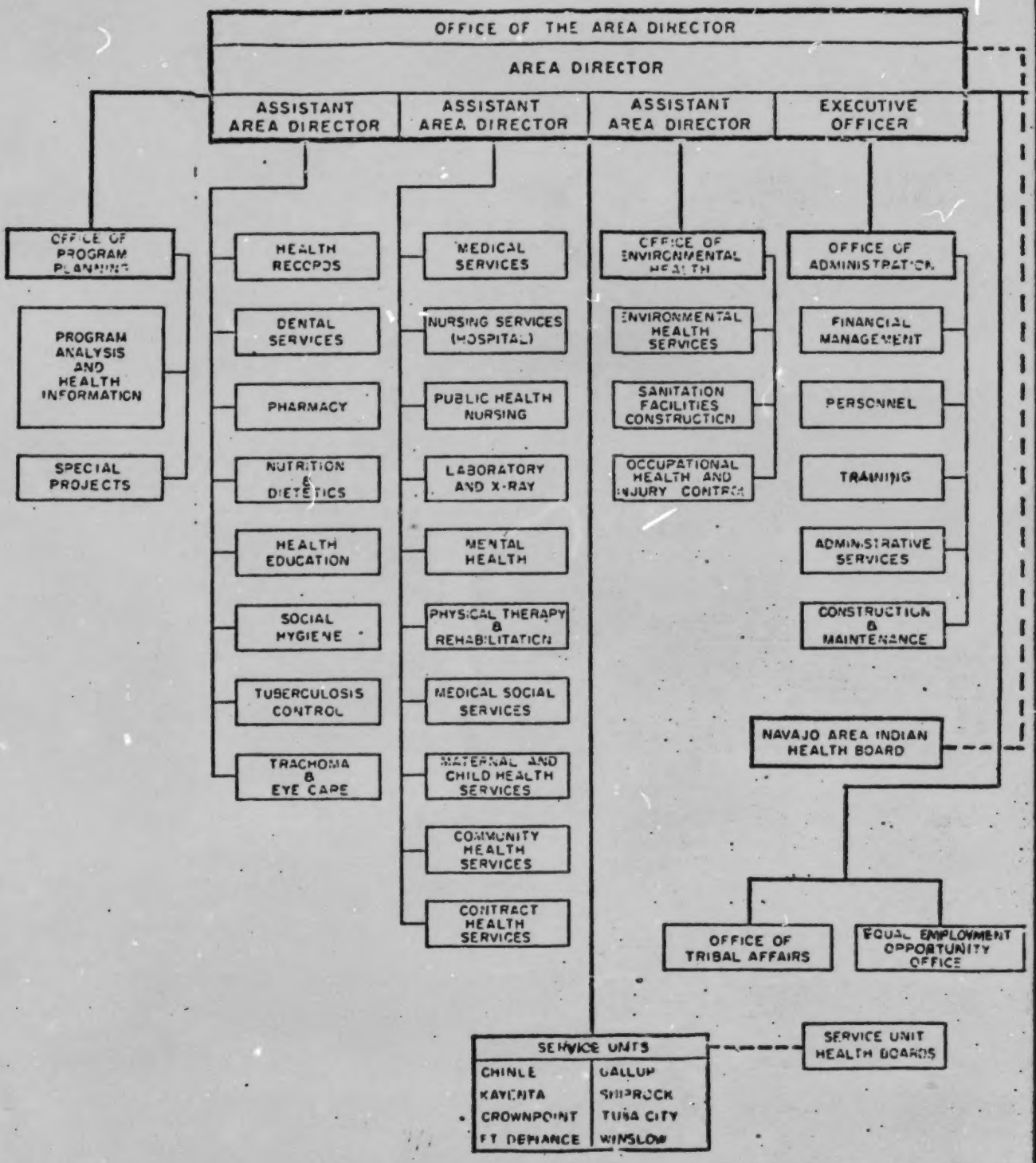


Table I-B-2

PORTLAND AREA OFFICE

ORGANIZATIONAL CHART

U.S. Department of Health, Education, and Welfare
Public Health Service
Health Services & Mental Health Administration
Indian Health Service
Portland Area Office

DIRECTOR
DEPUTY DIRECTOR
EXECUTIVE OFFICER

[illegible] SERVICES OFFICE

DEVELOPS, EVALUATES, AND PROVIDES GUIDANCE FOR THE AREA SOCIAL SERVICES PROGRAM, ESTABLISHES AND MAINTAINS LIAISON WITH STATE AND LOCAL AGENCIES AS CONSULTANT TO THE AREA DIRECTOR AND HIS STAFF, AND TO SERVICE UNIT HEADS, PLANS AND PARTICIPATES WITH THE AREA PUBLIC HEALTH NURSE IN PROVIDING NURSING SERVICES IN HOMES AND FAMILY GROUPS, PLANS AND ADMINISTERS THE AREA PROGRAM OF SOCIAL SERVICES FOR ADULTS AND AGED INDIANS, PROVIDES SPECIALIZED ASSISTANCE TO STAFF OF MENTAL HEALTH TEAM, PROVIDES DIRECTION AND SUPERVISION TO SOCIAL SERVICES STAFF ASSIGNED TO MENTAL HEALTH TEAM, ASSISTS AND ADVISES STAFF IN THEIR ROLE IN THE MENTAL HEALTH PROGRAM, PARTICIPATES WITH PSYCHIATRIC AND PSYCHOLOGICAL CONSULTANTS IN CASE CONFERENCES, ESTABLISHES CRITERIA FOR SOCIAL SERVICES STAFFING.

MENTAL HEALTH OFFICE

DEVELOPS, EVALUATES, AND PROVIDES GUIDANCE FOR THE AREA MENTAL HEALTH PROGRAM. SERVES AS CONSULTANT TO THE AREA DIRECTOR AND HIS STAFF, SERVICE UNIT DIRECTORS AND THEIR STAFFS ON MENTAL HEALTH MATTERS. IN THE MENTAL HEALTH FIELD, PLANS AND COORDINATES WITH STATE, LOCAL SOCIAL AGENCIES, IN PROVIDING GUIDANCE TO SERVICE UNIT MENTAL HEALTH TEAMS IN THEIR ROLE IN THE MENTAL HEALTH PROGRAM. PROVIDES DIRECTION AND SUPERVISION TO PROFESSIONAL AND SUBPROFESSIONAL PERSONNEL ASSIGNED AND DETAILED TO THE SERVICE UNITS.

PERSONNEL AND TRAINING OFFICE

PLANS AND ADMINISTERS THE AREA PERSONNEL MANAGEMENT PROGRAM, DEPENDING UPON THE DELEGATION OF POSITION CLASSIFICATION, STAFFING, TRAINING DEVELOPMENT AND EVALUATION AND DISTRIBUTION, EMPLOYEE RELATIONS, EMPLOYEE ORIENTATION, EMPLOYEE AWARDS, AND PLACEMENT AS DELEGATED AND APPROVED. COORDINATES PERSONNEL ORIENTATIONS FOR AREA OFFICE AND FIELD ACTIVITIES. MAINTAINS LIAISON WITH LOCAL SERVICE ORGANIZATIONS AND OTHER AGENCIES ON PERSONNEL MATTERS. PLANS, COORDINATES AND EVALUATES TRAINING NEEDS AND ACCOMPLISHMENTS.

BUDGET OFFICE

SERVES AS CONSULTANT TO THE DIRECTOR AND HIS STAFF AND TO SERVICE UNITS ON MATTERS AND PROCEDURES OF NATIONAL, DEPARTMENTAL AND PUBLIC HEALTH SERVICE BUDGETS AND FINANCIAL REPORTS. PREPARES AND PRESENTS BUDGET ESTIMATES IN ACCORD WITH PROVIDED PROGRAM PROPOSALS, CONSULTATIONS WITH AREA PROGRAM OFFICIALS AND ALLOCATION OF FUNDS PERTAINING TO THIS ACTIVITIES. ADVISES AVAILABILITY FUNDS FOR BUDGETED PROGRAMS BY MAINTAINING RECORDS OF FUNDS AND BY UTILIZING FINANCIAL REPORTS ACCORDED BY THE DISBURSING AREA ACCOUNTING POINT.

WELFARE ASSISTANCE OFFICE

DEVELOPS AND PROVIDES A COMPREHENSIVE HEALTH PUBLIC INFORMATION PROGRAM FOR AREA, TO WIDEST DISSEMINATION OF HEALTH EDUCATION AND ASSISTANCE TO DEVELOP UNITY IN AFFECTING PLANNING HEALTH PROGRAMS, SUBJECTS. PLANS FOR TECHNICAL SERVICES GOVERNMENT MATERIALS. SERVES AS A PHASE OF THE PROFESSIONAL SERVICE PLAN. PROVIDES CURRENT MEDICAL INFORMATION TO PROFESSIONAL AND NON-PROFESSIONAL STAFF.

PROGRAM STATISTICS OFFICE

COLLECTS AND ANALYZES DATA ON HEALTH SERVICES RENDERED IN THE SERVICE UNITS MAINTAINS STATISTICAL REPORTING SYSTEM TO MEET REPORTING AND PLANNING REQUIREMENTS OF THE AREA AND THE SERVICE UNITS. PROVIDES COMPARATIVE DATA RELATING TO TYPE AND VOLUME OF SERVICES PLANNING. COLLECTS HEALTH RELATED DATA, INCLUDING VITAL.

PHARMACY OFFICE

RESPONSIBLE FOR THE PROMOTION AND ADMINISTRATION OF AN AREA-WIDE PHARMACY PROGRAM, PROVIDES ADVICE ON ALL PHARMACY ACTIVITIES, INCLUDES AID TO AFFAIRS, PROFESSIONAL AND PROFESSIONAL, ALLIED, NURSING, DENTAL, LABORATORY, AND X-RAY, INTEGRATION OF SERVICE FACILITIES, PURCHASING, AND SERVICE DETAILS IN CONFORMANCE WITH INDIAN HEALTH SERVICE POLICY AND GOOD PHARMACY PRACTICES.

PROGRAM PLANNING AND EVALUATION OFFICE

RESPONSIBLE FOR ALL ASPECTS OF PROGRAM PLANNING AND EVALUATION. THIS INCLUDES BUT NOT LIMITED TO: PREPARATION OF REPORTS, SURVEYS, INTERVIEWS ETC., MAINTENANCE OF RECORDS, AND INFORMATION ON POPULATION STATISTICS, LEADS TO FINANCIAL, STATE AND SOCIAL PROBLEMS OF HEALTH FIELDS, STATISTICS, SOCIAL, CULTURAL OR OTHER DEMOGRAPHIC DATA. RESPONSIBLE FOR THE REVIEW AND APPROVAL OF SERVICE UNIT AND AREA PLANS PRIOR TO SUBMISSION TO THE DIRECTOR.

NURSING OFFICE

REVIEWS, COORDINATES, AND EVALUATES THE NURSE SERVICES IN THE AREA. PROVIDES CONSULTATIVE, TECHNICAL ASSISTANCE, AND GUIDANCE TO THE PUBLIC HEALTH AND CLINICAL NURSING STAFF. PARTICIPATES WITH AREA AND SERVICE UNIT STAFFS, TRIBAL BODIES, OTHER AGENCIES, AND PUBLIC HEALTH NURSES, ETC., IN TOTAL PROGRAM PLANNING AND IMPLEMENTATION. PLANS FOR PROFESSIONAL GROWTH OF NURSING PERSONNEL.

CONTRACT HEALTH SERVICES OFFICE

DEVELOPS, COORDINATES, AND EVALUATES SERVICES PROVIDED THROUGH CONTRACTUAL ARRANGEMENTS. ESTABLISHES GUIDANCE TO AREA AND FIELD STAFF CONCERNING THE PURPOSES AND PROCEDURES, MAINTAINS LIAISON WITH LOCAL GROUPS WITH PHYSICIANS, DENTISTS, HOSPITALS, AND OTHERS CONCERNED WITH CONTRACT HEALTH SERVICES. PARTICIPATES IN DEVELOPING AND ADMINISTERING THE AREA BUDGET.

ENVIRONMENTAL HEALTH OFFICE

PLANS, DEVELOPS AND APPRAISES THE ENVIRONMENTAL HEALTH ACTIVITIES CARRIED OUT BY THE ENVIRONMENTAL HEALTH SERVICES BRANCH AND THE SANITATION FACILITIES CONSTRUCTION BRANCH. COORDINATES ARE ACTIVITIES AMONG THESE BRANCHES AND SERVES AS PRINCIPAL ADVISOR TO THE ENVIRONMENTAL HEALTH FIELD. RECOMMENDATIONS WITH TRIBAL GROUPS AND OTHER AGENCIES IN PLANNING AND OPERATION OF SERVICES.

HEALTH EDUCATION OFFICE

COORDINATES, EVALUATES, AND PROVIDES GUIDANCE FOR THE AREA HEALTH EDUCATION PROGRAM. SERVES AS A CONSULTANT TO THE AREA DIRECTOR AND HIS STAFF, AND TO ALL THE SERVICE UNITS, ON MATTERS RELATING TO HEALTH EDUCATION. COORDINATES WITH ALL STATE HEALTH ORGANIZATIONS IN PROMOTING HEALTH EDUCATION AMONG INDIANS.

DENTAL OFFICE

DEVELOPS, COORDINATES, AND EVALUATES THE AREA ORAL HEALTH PROGRAM. ESTABLISHES STANDARDS FOR STAFFING, TECHNICAL PROCEDURES, AND USE OF DENTAL FACILITIES. COORDINATES THE ORAL HEALTH PROGRAM WITH OTHER FEDERAL AGENCIES, STATE AND LOCAL GOVERNMENTS, AND SCHOOL SYSTEMS.

TRIBAL AFFAIRS OFFICE

DEVELOPS AND MAINTAINS LIAISON WITH TRIBAL ORGANIZATIONS, STATE OFFICIALS, AND INTERESTED GROUPS. PARTICIPATES IN AREA PROGRAMING AND ADVISES ON IMPACT OF PLANS ON TRIBAL GROUPS. PROVIDES INITIAL AND CONTINUING ORIENTATION TO AREA PERSONNEL ON THE CULTURAL AND SOCIAL ASPECTS OF THE VARIOUS TRIBES IN THE AREA.

MEDICAL SERVICES OFFICE

APPRAISES PROFESSIONAL AND PROGRAM SERVICES RELATIVE TO THE MEDICAL CARE AND PREVENTIVE HEALTH SERVICES PROVIDED TO INDIAN PEOPLE. ASSISTS IN COORDINATION OF CONTRACT MEDICAL SERVICES. MAINTAINS LIAISON WITH PROFESSIONAL HEALTH SERVICE PERSONNEL. PROVIDES ADVICE AND CONSULTATION TO THESE MATTERS TO SERVICE UNITS AND AREA OFFICE STAFF.

GENERAL SERVICES OFFICE

DEVELOPS AND ADMINISTERS, TO MEET THE PURCHASE AND SUPPLY NEEDS, PROPERTY MANAGEMENT BRANCH, AND OFFICE SERVICES BRANCH, THE TOTAL GENERAL SERVICES ACTIVITIES FOR THE AREA. IN CLOSE LIAISON WITH GSA AND OTHER FEDERAL AGENCIES, STATES, AND LOCAL GOVERNMENTS ON GENERAL SERVICES. DEVELOPS AND ADMINISTERS THE AREA SOCIAL RELATIONS ACTIVITIES.

NURSING AND DIETETICS OFFICE

PLANS, DEVELOPS, COORDINATES AND EVALUATES A COMPREHENSIVE NURSING AND DIETETICS PROGRAM AS PART OF THE TOTAL HEALTH PROGRAM. RENDERS AS CONSULTANT ON MATTERS AND DIRECTIVES TO THE AREA DIRECTOR, ASSURE THAT DIRECTORS AND THEIR STAFFS, PARTICIPATE IN AREA PROGRAM PLANNING, PROJECT DEVELOPMENT, AND EVALUATION, DIRECTS, SUPERVISES, AND ASSISTS AND HELPS IN DEVELOPING AND MAINTAINING STANDARDS IN NURSING AND DIETETICS, MAINTAINS LIAISON WITH TRIBAL GROUPS, NEARBY AGENCIES, AND SCHOOLS. CONSULTANT ON PROBLEMS IN NURSING AND DIETETICS AND RECOMMENDATIONS IN REGARD TO SOLUTIONS AND RESOLVES

ASSISTANT DIRECTOR

DEVELOPS AND COORDINATES SERVICE UNIT PROGRAM PLANNING [illegible] IN THE DIRECTION OF NEW SITE AND PROMOTION OF HEALTH PROGRAMS FOR THE SERVICE UNIT. ASSURES FULL UTILIZATION OF RESOURCES AND GOOD RELATIONS IN THE DIRECTION OF THE SERVICE UNIT, THE AREA, AND THE

ASSISTANT DIRECTOR

PLANS AND IMPLEMENTS AN EFFECTIVE ANIMAL DISEASE CONTROL AND ERADICATION PROGRAM DESIGNED TO REDUCE A REDUCTION IN THE NUMBER OF DEAD AND DISEASED ANIMALS KNOWN TO ASSESSMENT.

CONSTRUCTION AND MAINTENANCE OFFICE

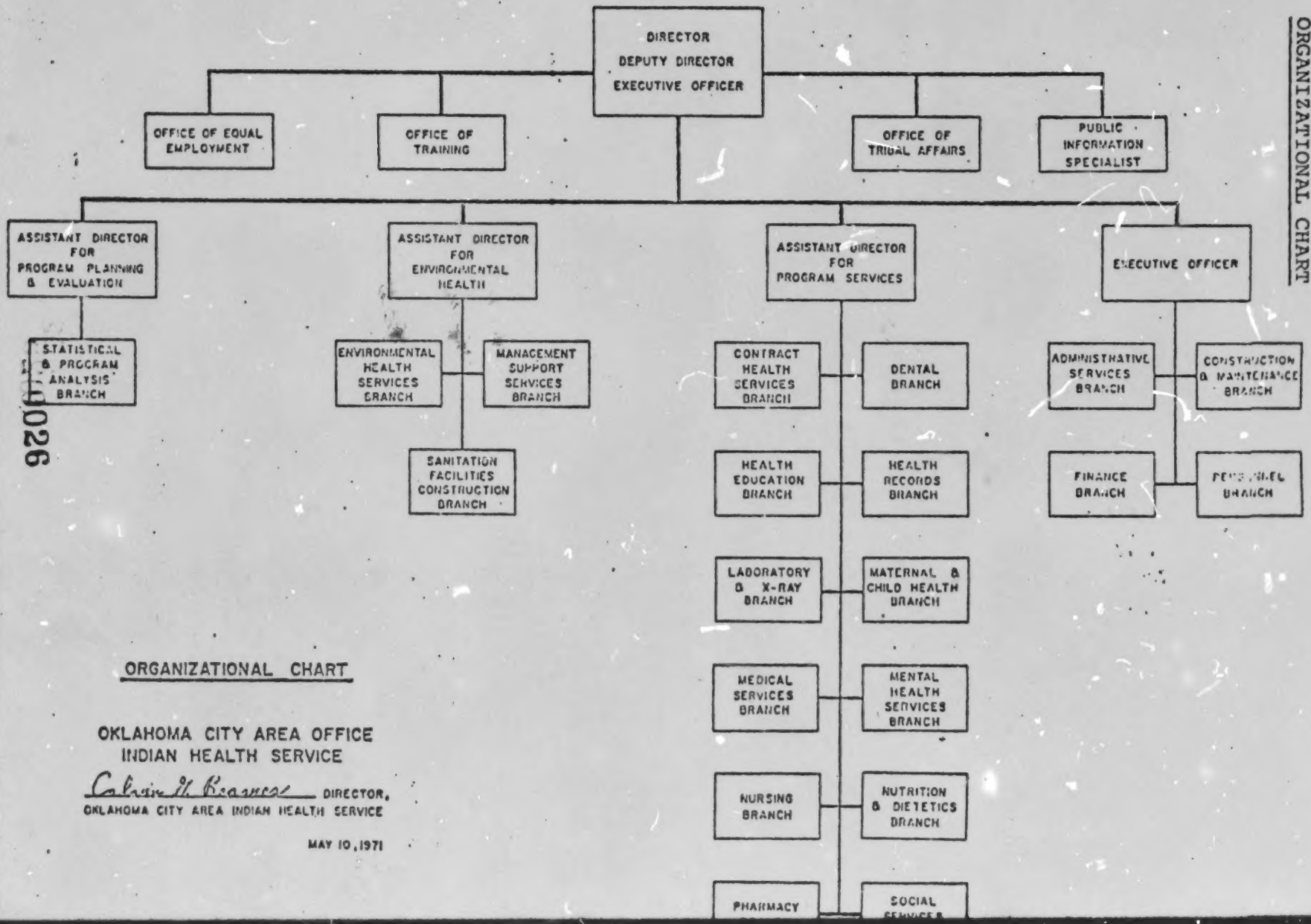
ORGANIZES AND COORDINATES CONSTRUCTION AND MAINTENANCE ACTIVITIES FOR THE AREA. IN CONSULTATION WITH THE PROGRAM PLANNING AND EVALUATION OFFICE, DEVELOPS LONG-RANGE PLANS FOR CONSTRUCTION, MAINTENANCE, AND REPAIR. PREPARES PRELIMINARY AND ARCHITECTURAL DRAWINGS, TECHNICAL STANDARDS, PLANS, SPECIFICATIONS, AND COST ESTIMATES. DEVELOPS AND ADMINISTERS THE AREA FIRE AND SAFETY ACTIVITIES IN IHS FACILITIES.

APPROVED BY:

[illegible]
C. E. Dixie, Jr., M.D.
DIRECTOR,
PORTLAND AREA INDIAN HEALTH SERVICE

[illegible]
[illegible], M.D.
DIRECTOR
INDIAN HEALTH SERVICE

[illegible] 0025



ORGANIZATIONAL CHART

OKLAHOMA CITY AREA OFFICE
INDIAN HEALTH SERVICE

Calvin H. Reaves DIRECTOR,
OKLAHOMA CITY AREA INDIAN HEALTH SERVICE

MAY 10, 1971

026

3. Service Units

The Service Unit (SU) is the basic operating level of IHS. It is through the SU that health care is delivered to Indians. Like the AO's, the shape of the SU will vary depending on the size of the population it is serving, the Area it is in, and its budget allocation. The Service Unit Director (SUD), assisted by an administrative officer and sometimes other support staff, runs the SU. The chief medical officer, or chief clinician, is the head of the medical staff.

The IHS Service Unit provides service through two methods of delivery: direct delivery of health service and contract health services. Direct services, both in- and out-patient, are those provided by IHS staff in IHS facilities (hospital or clinic), while contract health services are purchased by IHS from the private sector or from other governmental health programs such as military hospitals.

Direct care services include inpatient services provided at IHS hospitals, and outpatient services provided at clinics connected with hospitals, free standing clinics, and field stations. IHS also runs various outreach and preventive health programs, including public health nursing, mental health, nutrition, health education, and social services. A large Service Unit may have a full-time nutritionist, health educator, or mental health worker, while a smaller one might utilize these specialists only part-time, sharing their services with other reservations or hiring them part-time from the private sector. Finally, there is the environmental health office, authorized under amendments to the Transfer Act to help Indian reservations install sanitation systems and equip individual homes with water and waste facilities. 1/

4. Indian Health Boards

Indian Health Boards have developed or are being developed to parallel many of the IHS structures. The National Indian Health Board (NIHB), composed of members of each of the Area Health Boards, has an office and full-time staff located in Denver. In addition to working with the IHS national office on policy development, the NIHB conducts consumer evaluations under contract with IHS. Each Area Office has a counterpart Area Indian Health Board (AIHB) composed of tribal representatives from each of the Service Units under the Area's jurisdiction. Several have their own full-time staff; the others receive staff support from the IHS Area

1/ U.S. 86th Congress. Public Law 86-121, July 31, 1959.

Office. Like the NIHB, several of the Area Boards have conducted consumer evaluations of IHS under contract with it. Most, though not all, Service Units have an Indian Health Board, whose members are elected or selected by whatever method is decided on by the tribe. They advise their Service Unit Director and perform various additional roles. Some reservations have either no Board or have a Tribal Health Committee that functions as a Board. 1/

1/ Because the shapes and roles of the Health Boards vary so much from one place to another, this description is as neutral as possible, to provide background for the first part of the Study. A thorough description of the Boards and the different roles they have assumed is the subject of the section on Indian Involvement.

I. C. IHS RELATIONSHIP TO HEW

The transfer of IHS to HEW in 1955 was accomplished despite the resistance of HEW, which has argued before Congress that IHS should remain in the BIA. 1/ This initial attitude set the pattern for the relationship between the two agencies for the next ten years. IHS became a small box in a distant corner of the HEW organizational chart. There was little interchange between the two, each acting as though the other did not exist. HEW had no other Indian programs, did not understand Indians, and apparently did not want direct involvement in Indian problems. IHS, perceiving its own exclusive responsibility for the health of Indians, saw HEW as having nothing positive to offer Indians and felt that the less contact it had with its parent department, the better. Over time, however, a number of changes in HEW, including the termination of other direct health care programs; the increase in the amount of money available for health programs to the general public and thus to Indians as citizens; plus increased involvement by HEW in Indian matters; have led to a different, less isolated relationship between IHS and the other parts of HEW.

1. HEW Impact on IHS

IHS is an agency of the Health Services Administration (HSA) under HEW. Its chain of command is through the administrator of HSA to the Office of the Secretary of HEW. HEW must approve the budget proposed by IHS before it is submitted to OMB and controls the number of staff positions or slots that IHS is allocated. It oversees Congressional presentations made by IHS and determines the final position of the Department on legislation before Congress that may impact Indian health. It is responsible for insuring that IHS policy is in conformity with Presidential statements on Indians and with general Administration and departmental policy. Persons interviewed indicated that while HEW sets some "Indian" policy for IHS, its major impact on the IHS program is through the application of Administration and departmental policy to IHS. The two most significant of these policies are the general HEW opposition to direct care programs, and the Administration's effort to hold down the total number of federal employees.

HSA has two kinds of health programs--direct and indirect. An indirect health care program is one in which the federal government provides some or all of the funds, but leaves the actual delivery of services to non-federal health providers, be they state, local, or private. The Maternal and Child Health Program and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) grant-in-aid program are examples of in-

1/ See letter from Oveta Culp Hobby, Secretary of HEW to Chairman, Senate Committee on Interior and Insular Affairs, May 28, 1954, in the Senate Report accompanying the Transfer Act Bill, op. cit., p.16.

direct programs. A direct care program is one in which the federal government provides the funds and also runs the delivery system; the facilities are federal buildings, and the health stafff are federal employees. In addition to IHS, the Veterans Administration hospitals and the urban PHS hospitals are examples of federal direct care programs. IHS is now the most comprehensive direct care health program administered by HEW. For a number of years, HEW has been opposed to federal SU direct health care programs. This position stems from a philosophy that the federal government should not itself be a health provider--instead the actual delivery of health care should be the responsibility of local, public, or private health providers and the federal government should be primarily a source of money and technical assistance. 1/ Implementing this policy, HEW has eliminated a number of direct care programs and recommended the closing of urban PHS hospitals.

This policy places IHS in the awkward position of being one of the few major direct care programs in a department philosophically opposed to federal direct care programs. The issue has important implications for Indians because a job freeze can have a much more severe and immediate impact on a direct care program. It can mean the loss of a nurse or ambulance driver position which, in turn, can directly affect the life and death of members of the program's service population.

IHS officials feel that HEW is no longer responsive to these kinds of distinctions. In the past the Surgeon General represented the direct care programs before HEW policymakers and was able to influence HEW to adopt two different policies on such matters as job freezes--one for the rest of HEW programs and a more flexible one for its direct care programs. With the demise of the Surgeon General's power and the disfavor into which direct care programs have fallen, IHS officials feel that HEW has become staffed with persons who do not understand that "it takes people and not just a check to run a direct care program." As a result, freezes are being applied to IHS direct care services without any allowance being made for the impact on the life or death of Indians. Freezes were mentioned continually in the field interviews as one of the biggest obstacles to IHS being able to improve the services it is now providing.

The Director of IHS has been spending substantial time as the new advocate for direct care programs, trying to influence HSA and HEW officials to recognize and be responsive to the critical distinctions between direct and indirect programs. The Director feels that HSA is now becomming more sensitive to the issue and will support IHS in its efforts. If this is the case, then perhaps some of the problems IHS staff felt resulted from HEW opposition to direct care programs will be alleviated. It is an area of major concern to the delivery of services to Indians and needs to be followed closely.

Another larger question for Indians is what will be the impact of HEW's aversion to direct care programs on the continuation of IHS in its present mold. IHS staff felt that HEW reluctantly accepts the fact that money alone cannot replace the IHS delivery system in the absence of alternative direct care providers on or near most reservations. They noted this acceptance

1/ Elliot Richardson's Master Plan

of IHS will probably continue only until the private medical system (or tribal medical system) is in a position to take over that job. Some staff believed that HEW was using the IHS budget process to foster this change. They have maintained that increases in the IHS contract health services program without similar increases in its direct care program were due to HEW's stance and were intended to wean Indians away from IHS and to encourage the private medical system near reservations.

The greatest concern expressed was over the impact of the HEW policy on IHS efforts to encourage tribal involvement in health programs under the President's policy of Indian self-determination. Allegedly, HEW and HSA are encouraging IHS to expedite tribal takeover of the health delivery system as part of an attempt to get IHS out of the direct care operation. However, IHS takes the position that self-determination is not just another word for contracting programs over to the tribes--indeed, that pushing tribal takeover is a violation of the whole concept of self-determination. A tribe should be allowed to take over as much or as little of the IHS program as it wants, according to the IHS director. True self-determination means that if a tribe wants to run the hospital and hire the doctors, it can do so, or it may just want to have some say in policymaking, but not run the program. Therefore, while the commitment of IHS to self-determination in health seems constructive and well-intentioned, the attitude of IHS staff is that Indians should look closely at the role of HEW in this process.

2. IHS Impact on HEW

For many years, first under the BIA, and then under HEW, IHS was perceived by federal officials and Indians as the exclusive source of health services to Indians. With the increase in federal health programs and the opening up of the reservations in other federal programs, particularly OEO's, this concept has given way to an expanded approach that substantially increases the amount of federal health funds available for Indians. It is now recognized that Indians have dual rights or entitlements to federal health services. First, Indians are entitled to the services of the Indian Health Service on the basis of their unique legal and historical relationship with the federal government. This "special relationship" does not, however, impair their right to participate in health programs that are available to the American public as a whole. Indians are citizens, and under the Fourteenth Amendment to the Constitution and Title VI of the Civil Rights Act of 1964, they are entitled to the same equal access to state, local, and federal health programs as are other citizens. 1/

That Indians have a dual entitlement has presented problems for officials in the federal and state governments. But it is

1/ Memorandum of Agreement between HEW OCR, IHS and MSA.

firmly established 1/ that Indians are entitled to receive grant or beneficiary benefits in addition to their IHS benefits in the same way that a veteran has the dual option of using VA benefits or Medicare benefits. 2/

While officially recognized, the principle of dual entitlement has not always been followed in the development of HEW legislative proposals or in the implementation of HEW health programs. The problem is that HEW has no central office to coordinate Indian policy and protect the Indians' rights of entitlement to general HEW programs. The termination of the Office of Indian Affairs (OIA) in HEW's Office of Special Concerns (OSC) has eliminated the Indian advocacy role from HEW, and the new Office of Native Americans program in the Office of Human Development has not yet assumed this function.

Without a coordinating agency on Indian policy in HEW, legislation often is drafted and programs implemented in ways that make it difficult, if not impossible, for Indians to exercise their rights to participate in general HEW health programs. Legislation on federal grant-in-aid programs is drafted which makes state and local governments eligible to receive grants but which fails to include Indian tribes. As a result tribes may not apply directly for such grants and must work through often uncooperative state and local governments (e.g. the Older Americans Act). Programs such as Medicaid, a state-federal program, have been implemented without any system to assure that states fully included Indians in the programs. As a result states have been negligent in informing Indians about Medicaid and in helping them to enroll in it.

To fill this void, as well as to carry out certain functions assigned to it in the President's 1970 Message on Indians, IHS has assumed the role as advocate for Indians in HEW. A major aspect of this advocacy role involves impacting general legislation to protect Indian rights. IHS plans to become involved in the development of HEW health legislation in order to preserve Indian rights but feels that it is not in a strong position to impact proposed legislation because it is too far down in the HEW hierarchy and too far away from the Office of the Secretary, where legislation is developed and reviewed. While IHS may be asked how the legislation will impact IHS, it will not be asked how it impacts Indian health in general, nor is any other agency in HEW in a position to provide this kind of information. Urban Indians are particularly shortchanged by this approach. General health legislation will become of increasing importance to Indians, as the federal government assumes increasing responsibility for health care financing, as exemplified by the recent passage of HMO legislation

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1/ Ibid.

2/ A more detailed discussion of dual entitlement is contained in the Sections on Third Party Resources and National Health Insurance. A brief discussion is provided here to set the foundation for the discussion of the role IHS plays in the rest of HEW.

and introduction of legislation proposing a national health insurance program. IHS recognizes that its effort to impact HEW health legislation is still no substitute for a central office to coordinate legislative impact on Indian health, as well as to influence social services, welfare, or education as they affect Indians.

A second component of the IHS advocacy role is in reminding other state and federal agencies of their legal obligation to include Indians in their beneficiary or grant programs. The President's 1970 Indian message made IHS the lead agency for "identifying, selecting, and coordinating efforts to benefit American Indians and Alaska Natives in the area of health services... to locate all potential resources which might be focused on increasing health services." This involves educating beneficiary programs that they have an obligation to service eligible Indians.

Finally, advocacy involves assuming the responsibility to help tribes apply for and obtain funding for such programs as alcoholism and mental health to supplement or fill vacuums in IHS services. IHS created an Office of Health Resources to act as liaison with other agencies in funding Indian projects and as a resource for tribes seeking such projects. This effort has met with mixed success. According to a former HSMHA official, other health agencies are reluctant to fund on reservations because their programs are swallowed up by IHS and receive little recognition. Some tribal groups have also indicated a lack of aggressiveness on the part of the Office in helping them pursue their right to grant programs. However, IHS can only encourage such involvement--it cannot mandate it.

3. Decentralization in HEW and IHS.

Over the past few years, HEW has initiated a policy of decentralizing authority over most HEW programs to the ten HEW regional offices. Most of the funding authority for HEW health programs now rests with the ten regions. As a result, IHS, operating out of the Area Offices, is in a particularly weak position to advocate for Indians with other HEW health programs. Like the rest of HEW, most regional offices have had little experience in working with reservation Indians and comparatively little with urban Indians. They have tended to view Indian health as exclusively an IHS concern. The region's primary constituents have been states and, secondarily, local governmental units. To obtain funding, Indians will have to compete with these other government units--a new experience for many tribes.

With the implementation of the HEW decentalization policy, the regional offices have been asserting that the IHS Area Offices, or their function, should be moved to the HEW regional offices and coordinated with the other HEW programs.

IHS and various Indian groups have resisted this on several grounds. First, moving the Offices without the consent of the tribes would be a violation of the concept of self-determination.

Second, Area Offices are located near the reservations, while the regional offices are not. Third, the tribes have developed working relationships with the Area Offices, while they have not with the regional offices. Regional offices have traditionally seen the states as their constituents, and in any conflict between the states and the tribes, the regional offices have opted for the states. IHS maintains that if the regional offices want to serve Indians, they presently have enough authority through the grant programs to prove their ability to assist Indians, and they must do that before Indians can be willing to put the direction of their direct health care programs in regional hands.

The decentralization of authority to the HEW regional offices has raised a host of problems for Indian tribes seeking federal grant funds and has made for a very confused situation. Presently, for some grant programs, Indian tribes can go directly to Washington and work through the Indian desks of those programs. For others they must go through the regional offices or to the relevant state offices. Various Indian groups are working on strategies to persuade the federal government to put some order into this system and to remove some of the obstacles faced by Indians at each of these levels--not just for health programs, but for all HEW programs (education, social services, etc.).

To assist the regional offices in relating to Indians and vice versa, IHS has established a liaison office at each regional office in regions where many tribes are located (Dallas, San Francisco, Chicago, Denver, and Seattle). These positions will be or have already been filled with persons chosen mutually by IHS and the HEW regional health administrators. Under the direction of the regional health administrator, the individual will serve as liaison between the regional office and IHS, assisting the regional office to carry out its objectives in Indian health and serving as an Indian health advocate within the regional office setting. He/she will also act as a resource person and focal point for tribes and other Indian groups seeking funding from the various HEW health programs. This liaison mechanism has not been fully tested and it is unclear if it will be sufficient to insure Indians their fair share of the federal grant-in-aid funds funneled through the regional offices.

The effort by IHS to impact the regional offices on behalf of Indians' primary right to general federal health programs is caught up, however, in a larger controversy between IHS and the regional offices. The issue seems to have been settled for the time being in favor of retention of the Area Offices, but it is likely to continue to affect the relationship of tribes, IHS, and the regional offices. 1/

1/ This is not intended to be an in-depth discussion of the issue of the decentralization of IHS to the regional offices. However, extensive written material on the issue is available, including: Federal Field Organization for Indian Programs, OMB, The Inter-Agency Staff Study Report, June 1972. American Indian Law Center, University of New Mexico Law School, An Indian Response to the Inter-Agency Staff Study Report, June 1972. Correspondence by NTCA, NCAI and The United Sioux Tribes to OMB.

I. D. DECISION-MAKING AUTHORITY

Indian Health Service decentralized decision-making authority from Headquarters to the Area Offices and from the Area Offices to the Service Units several years ago. The action was based on the concept that Indian problems and needs varied from tribe to tribe, and no one policy or structural model could meet all the different situations existing in the field. Delegating authority downward would give the staff responsibility for delivering the services and the decision-making powers it needs to shape the IHS program to the particular local situation.

Decentralization has important implications for tribal self-determination. With more authority vested at the Service Unit level, meaningful tribal control becomes more realizable. If more and more of the important policy decisions are made at the SU level, these decisions could be more easily controlled by the tribal health departments and Health Boards. Tribal representatives will have to make fewer trips to the Area Office or Washington to shape the IHS program to meet their reservation's needs. If a tribe decides to assume full control over its health programs, it will take over a local self-contained system rather than one that is overly dependent on AO and Headquarters participation. While this decentralization policy has been enunciated by IHS it has not yet been fully implemented in the field. The section below first analyzes the policy and then discusses some problems that have arisen in the process of implementing it.

1. The Policy

a. Decentralization from Headquarters to Area Offices

Under the new procedures, Headquarters no longer sets policy for the AO's; rather it sets out the broad parameters of the IHS policy in four annual IHS documents: The Operational Planning System (OPS), the Forward Plan, the Comprehensive Evaluation Plan and the IHS Director's opening statement in his presentation to Congress. The IHS manual also helps to establish these parameters. The AD's are expected to absorb the philosophy from these documents and from their meetings with the Director and then develop policies, procedures, and priorities guided by these parameters and by what is "legal, moral, ethical, and within budgeting instruments." 1/ For example, because the philosophy emphasizes Indian involvement, the AO's are expected to stress Indian involvement in their policies and priorities but the manner in which they pursue such involvement is at their discretion.

1/ Interview statement by Dr. Emery Johnson, Director, IHS.

Decision-making authority has been delegated to the AO's in most areas of management: planning and budgeting, administration of the contract health program, identification of health services to be delivered, and the relationship with other health programs and the HEW regional offices.

Headquarters still handles liaison with Congress and HEW, does long-range planning, provides backup services and resources for the AO's, monitors the AO programs, prepares the budget, and collects data and information.

b. Decentralization from AO's to SU's

The process of decentralizing authority from the AO's to the SU's is less well defined and has progressed unevenly. Some AO's have moved to reshape their decision-making process to enable SU's to exercise decision-making authority, while other AO's appear to be holding back.

The AO-to-SU decentralization plan has several components. First is the withdrawal of the considerable direct authority AO Branch Chiefs had exercised over their counterparts in the SU's. While Service Unit Directors (SUD's) were supposed to be the SU administrators, in the past they tended to be doctors who were in IHS for a two-year hitch, who performed the administrative tasks in addition to their medical functions, and who had neither the experience nor interest in administering the program. As a result, power and authority became concentrated in the Area Branch Chiefs, administratively-oriented career employees who were likely to be the only source of administrative continuity in the SU programs.

However, over the past few years, IHS has increasingly hired non-doctor SUD's who are administrators and career employees. With full-time administrators, greater authority could be delegated to the SU level. Toward this objective, IHS withdrew from the AO Branch Chiefs all direct authority over their counterparts in the SU. Now in the AO, only the AD has direct authority over persons at the SU level. The Branch Chiefs serve primarily as sources of technical assistance to the SU's.

The transition of the Branch Chief from authority figure to technical assistance resource has been difficult, with feuding between the AO's and the SU's, and each side accusing the other of being stubborn and not knowing what really needs to be done. But eventually the change will mean increased decision-making authority at the SU level, where it is more accessible to tribes and Health Boards.

Decentralization also entails the delegation of budget and fiscal authority to the SU level. Previously the AO did the priority planning and dictated their priorities to the SU's. Now the SU's are to do their own planning and priority setting. The AO's priorities are to provide the follow-through and back up work to help the SU's achieve their own priorities. Similarly fiscal management was previously handled by the AO's, and the SU's had little discretion in spending the funds allocated to them. Now the SU's are to be given greater discretion in allocating the funds within their SU area. This system gives the SU more freedom to fund and implement its own (or the Health Board's) priorities and to retain the benefits if it manages its money well. This revised approach also cuts down on the buck-passing by the SUD, since he can no longer use lack of fiscal control as an excuse for failing to carry out the tribal Health Board's priorities.

If they are to successfully delegate these authorities to the SU's, the AO's must first help the SU's to develop fiscal and planning capabilities. The Phoenix Area Office has done this more extensively than any of the other Areas visited. During this developmental period, it is training the SU staff in fiscal management and planning, is establishing clear definitions of the respective roles of the SU's and the AO's, and is monitoring the SU's closely to catch problems before they become serious.

2. Problems in the Implementation of the Decentralization Plan

The process described above is IHS's conceptual plan for decentralization. It is now being implemented with varying degrees of commitment and success at the different AO's. The process has important implications for tribes and Area Health Boards and they should monitor the process to insure that it is being done expeditiously and in a manner that promotes tribal interests.

In discussing the decentralization program, IHS staff raised several major problems they felt have arisen during its implementation.

a. Concentration of Power

According to field staff, IHS has always been run as a small, closely-knit, informal operation, dating back to the days when a small group of dedicated top staff set out to do something about the level of Indian health. It is still largely run that way. The Director, a small group of Headquarters staff, and Area Directors seem to be the core of the IHS decision-making process. This group meets together frequently to set IHS

philosophy and priorities and to discuss problems. IHS staff indicated that the decentralization process has tended to intensify the concentration of decision-making authority in this small group to the point that it interferes with the effective management of IHS.

At IHS Headquarters, power has concentrated in the Office of the Director. Issues are dealt with by the relevant staff from the different divisions "coming together" as an ad hoc task force to work on a particular issue, and disbanding when their work on that particular issue has been completed. But no one within the group has the responsibility or the authority for follow-up to see that the next step is properly implemented. The key link in such a system would be an office (or officer) that remains constantly on top of the management of the system.

Under the existing system this "key link" in the management system is the Director. 1/ However, because of all the other responsibilities he carries (working with HEW, OMB, Congress, providing leadership, etc.) he has not had time to spend at Headquarters exercising the broad decision-making and coordinating role the management system gives him. He has only been able to carry out his management role sporadically--when his time permits; as a result, management decision-making has become backlogged. An issue that came up time and again from the Area and field staff was the lack of smooth, ongoing management by Headquarters and the difficulty in getting timely, coordinated, decisions from it. Instead there was a feeling among staff and tribal leaders that the "only way to get things done in IHS is to go outside channels and somehow get the ear of the Director personally." This, however, just adds to the sporadic management system and antagonizes the staff that is bypassed in going directly to the Director.

A similar situation exists at the AO level. As a result of his central role in both the decentralization process and in promoting Indian involvement, the AD has become the focus of attention for the Area staff, the SUD's, and the tribal leaders. Because of the load that has been put on the AD's shoulders, the single most frequent complaint about the AO--from his staff, from SUD's, from Area Health Board members, and from tribal representatives--is that the AD is not sufficiently accessible to act on the vast number of decisions concentrated in his hands under the new system. It also makes it difficult for the tribes to hold the AD accountable since he can always avoid a decision by claiming he is too busy to get to it.

1/ Other than the Director, only the Executive Committee exercises decision-making authority but it is not structured (or intended) to provide smooth ongoing management.

Concentration of power in the hands of a "few good men" is one way to avoid a bureaucratic atmosphere and guide an agency in its transition to decentralization. However, as one staff person said, "IHS is no longer a small, intimate agency that can be run on an informal basis. The most important thing IHS presently needs is a thorough review of its management system." A system that would permit the process of decentralization to go forward, while avoiding the placing of so many responsibilities on a few persons, to the point of slowing down and disrupting the operation of the agency, would seem essential if IHS is to avoid major administrative difficulties.

b. Policy-Making: Headquarters vs. Area

IHS staff also felt that IHS Headquarters was holding on to much of the authority it claims to have delegated to the Area Offices. One staff person said that, "Decentralization is a phony. Headquarters delegates authority when it feels like it, and doesn't when it doesn't feel like it. As a result, when you make a decision at the Area level, you are never sure if you have the authority to do it. It is painfully unclear where authority begins and where it ends." Most staff, however, were less cynical. They accepted Headquarters' good-faith effort to decentralize, but were concerned about the confusion between philosophy and policy-making.

Another felt that decentralization was not working because: "AD's are afraid because they don't know what will be acceptable, and they are afraid to act because they are afraid of getting burned by Headquarters." Thus, despite its talk about decentralization and philosophy, Headquarters has a very clear idea of what it wants IHS policy to be, and it will intervene (erratically to be sure) when Area actions are not in line with Headquarters thinking. As a result, Area staff have been rebutted for exercising their presumed decentralized authority and are reluctant to repeat the error.

There was also a feeling that Headquarters uses the term "philosophy" to avoid the hard work involved in spelling out, in operational terms, the policies they have promulgated. "Headquarters is a bunch of armchair dreamers. They dream up nice ideas and philosophy, but when implementing them they fail to draw up the guidelines or lay the necessary ground-work for them." This was cited most often in the case of Indian involvement--that Headquarters had established Indian involvement as part of its philosophy, but failed to develop guidelines or other basic parameters that would give Area staffs a foundation from which to work.

The Area staff did not question the right of Headquarters to set the major directions of IHS, but it did criticize the method being used to do it, i.e., stating philosophy without elaborating or setting guidelines. Many of the complaints by IHS Area staff could be reduced if IHS assumed the function of developing guide-

lines for policy implementation which was established by HEW. Working through the difficult process of converting a stated philosophy into a workable policy, including the issuance of guidelines seems to be the essential signal to the staff that IHS leadership means business. The issuance of philosophy and the exercise of personal leadership are unfortunately insufficient and too ephemeral to lead an agency with a staff of 7,000 and a consumer population of 500,000. This is particularly true for the Indian involvement program with which some IHS staff disagree and are resisting.

Regulations and guidelines cannot come from the AO's because they do not have the staff to develop them, the authority to enforce them, or the legal right to publish nine separate sets of regulations in the Federal Register, one for each Area Office. Without legal regulations specifying what the AO's and SU's are specifically responsible for doing, neither Headquarters nor Indians have a means of holding the AO's or SU's accountable for their performance.

In contrast to the IHS approach, the guidelines for decentralization of the rest of HEW (drawn up by the HEW Under Secretary) distinguish between functions delegated to the regional offices and those retained by program headquarters. Among functions that remain with Headquarters, along with preparation of the budget, data collection, Congressional liaison, and the establishment of broad policies and priorities, is the "development of program policy, regulations, and project guidelines." What the Area staff is asking Headquarters to do is clearly included as Headquarters' responsibility according to HEW.

c. Changing Role of the Area Offices

The decentralization process also raises questions about the future role of the Area Office. Under decentralization the role of many of the Area staff is changing from supervising the SU staff to being a source of technical assistance to them. However, the AO's are not presently structured to perform a technical assistance role; yet without the technical assistance function the branch chiefs in many Areas have no role at all. A frequent comment by SU staff is that the branch chiefs are floundering without direction and that the Area staff is "top-heavy." The Area staff also seems to be more threatened than any other group in IHS by increasing Indian assumption of power, through employment in staff positions within IHS, and growing tribal control over programs at the SU level.

These factors have combined to create (1) a high level of frustration on the part of many Area staff, (2) concern among SU staff that the AO's are a drain on the IHS budget when funds are desperately needed at the delivery level, and (3) concern among Indian health leaders that the AO's are a barrier to increased Indian involvement in IHS. Whether the AO's have outlived their usefulness, whether they should be eliminated entirely, or whether

a new structure is needed in light of new conditions, has not been resolved, but staff in both the AO's and SU's are now addressing these questions with a new thoughtfulness. Some AO's are now taking steps to reshape their structure and role. For example, Portland and Phoenix are moving some of their Area staff into the field by stationing them in one SU, with responsibility for providing technical assistance to several SU's in the vicinity.

Given the transition now taking place both within the IHS and within the Indian community on control over Health Services, it is an apt time to take a hard look at the overall Area Office role. When this is done, Indians should have a strong and positive voice in its re-design.

I. E. PLANNING AND PRIORITIES

This study found that the planning process was not well understood by staff at the Area and Service Unit level. In many of the SU's visited, planning was presented to the Health Boards as the process of priority setting, which was defined narrowly as the process of listing needs by numerically ranking them. Minimal emphasis was placed on such factors as data accumulation or the making of choices within the constraints imposed by budgetary considerations and staff ceilings. Personnel were not instructed that program evaluation requires first the establishment of goals and objectives against which to judge program selection and priority-setting, or that the major purpose of monitoring was to find out whether IHS SU's were performing the tasks to which they had committed themselves in their Emphasis Plans.

Under IHS's policy of decentralization, the primary responsibility for planning has been delegated to the AO's and the SU's, so that planning will be localized and responsive to the needs of different Indian populations. The AO's and the SU's, therefore, have been assigned primary responsibility for identifying needs; setting priorities in light of established needs, the state of the art, and the resources available; and establishing task responsibilities and objectives for the programs in their localities. In turn, the responsibility for monitoring and evaluating the programs is also intended to be a local responsibility.

1. Emphasis Plans

The primary planning tool used by IHS and the Health Boards at the Area and SU level is the Emphasis Plan. In drawing up Emphasis Plans, the AO's and SU's and their Boards are setting priorities, but only priorities that can be achieved "within existing resources." This means that before the emphasis planning begins, the IHS budget has already been allocated to the various line item programs (direct care, field health, dental care, etc.), and staff positions have also been allocated. Within any given line item program, most of the money and staff time are already spoken for by pre-existing commitments.

Thus, the Emphasis Plan comes into the picture only after the decisions have already been made on how much money and staff must be assigned to each major area to preserve the essential service delivery program. The local Emphasis Plan can really consider only about 5% of the funds and perhaps 7% of the staff time, due to existing commitments. Thus, the Emphasis Plan, which is the primary planning document at the SU and Area levels and is the planning instrument which the Health Boards work with, affects only a very small part of the IHS program.

Planning and priority-setting for the other 95% of the IHS resources is done elsewhere than in the Area and SU Emphasis Plans.

Much of that planning and priority-setting are done in the budget process. IHS, HEW and OMB prepare a budget and submit it to Congress. Congress makes changes in that submitted budget on the basis of testimony presented by IHS, Indian organizations, medical organizations, and other interested parties. When Congress appropriates funds to IHS it breaks them out into line items which specify the general purposes for which the funds should be spent. IHS then allocates the funds to the Area Offices, breaking the money out into more specific line items. (See the Section on Budgeting for more detailed analysis of the budgeting process.)

The IHS Director indicated that the priority decisions made by IHS Headquarters in the budgeting process reflected the priorities set in the SU and AO Emphasis Plans and Program Plans, but that Congressional and Administration priorities at times would override them. The IHS field staff felt that this was not the case but that Headquarters substituted its own priorities for those of the Areas and SU's. Whichever is the case, it is clear that at present each group at each level has access to different data on IHS and, therefore, makes decisions on the basis of a different set of facts. Without a comprehensive planning mechanism which begins with the Health Boards, in which the different perspectives can be reconciled into a single complete data picture of the state of Indian health, each group inevitably comes up with a different set of priorities and then attempts to use its influence to achieve those priorities.

Secondly, much of the programming in IHS is "historical." Programs are continued from year to year, and the amount of resources allocated to them is not based on a planning process but rather on how much money they were allocated the year before, which in turn was based on the previous year's allocation, and so on. The absence of appropriate planning procedures contributes to this situation of funding a program mainly because it was there the year before, but there are also other reasons. According to IHS staff, once a program gets established it becomes a source of employment on the reservation and thereby develops a momentum of its own. Tribal government becomes vociferous in protesting the termination of any ongoing health program, even if it is no longer needed because it may mean the loss of jobs for Indians. However, if tribes participated in the planning process and could examine the same data as IHS utilizes, some of these problems could be overcome.

When a given program is put in the hands of the AO's, the Areas also feel a strong commitment to carry on existing programs. This is done without any formal mechanism for periodic review to determine if, given the priorities, the approaches presently utilized are, in fact, the best ways to achieve the Area's priority objectives. Since most of the new monies coming to the Areas are already allocated, there is little maneuvering room within which the Area can make program changes from year to year, even if their needs or priorities do change.

2. Area and SU Level Input and Implementation

The method used to develop the Emphasis Plan varies extensively from one AO to another. In one Area Office, the Emphasis Plan was compiled from packages submitted by each of the Area Branch Offices. The SUD's and SU Health Boards had little role in the process. The Branches set their priorities primarily on the basis of mortality and morbidity data, though the Area Director admitted that the Indian community does not always accept the implications of data when they conflict with its own perceptions.

In contrast, starting this coming year, the Phoenix Area Office Emphasis Plan will derive almost completely from the Service Unit Emphasis Plan. The Area Office will read the SU Plans to determine what help the SU's will need to be able to accomplish their stated objectives. The Area Office priorities will be determined by what it will have to do to assist the SU's to carry out their Plans. Thus, for Phoenix, the Area planning and priority process will proceed from the delivery level up. While the IHS position has long been that all planning is initiated at the SU level and progresses upwards, the Phoenix arrangement was the only one seen where a clear mechanism for doing so had been established.

At different SU's, the process for preparing Emphasis Plans also varied radically. There were several common points, however. Almost all of the SUD's interviewed considered the Emphasis Plan to be an inadequate planning document. The most commonly raised point was that emphasis planning must be done "within existing resources" so there were rarely adequate resources to achieve the priorities established in the Plan. SUD's also felt that the failure of AO's to monitor the Plans was a signal that the Plans were not to be taken seriously. Others mentioned that they lacked the data to do adequate emphasis planning.

A large number of AO's and SU's attempted to involve the Health Boards in the emphasis planning process. However, almost none of them had found an adequate approach for doing this. Both the Boards and the IHS staff talked about the frustration they experienced in trying to work together in establishing priorities and developing Plans. (See the Section on Indian Health Boards for more detailed discussion of this subject.)

In an effort to correct these problems the Phoenix AO is training the SU's in good planning techniques. IHS has a sophisticated data system on illness and utilization, maintained for each SU and stored in computers in Albuquerque. The Area Office is instructing the SU's how to tap this excellent data source and how to use it in their planning process. The AO said they are also insuring that the SU's involve tribes and Health Boards in the planning process. When the SU brings its Emphasis Plan into the AO for review, tribal leaders are invited along to insure tribal input into the Plan. The SU must develop quarterly status reports on their progress in achieving the objectives set out in their Plans.

Even with tribal involvement in the drawing up of the Plans, there was some question as to whether SU's carried out their Emphasis Plans or actually followed the priorities established in conjunction with the tribes. 1/ The primary factor, acknowledged by staff at both the Area and SU level, is that the programs IHS actually emphasizes are not found in the Emphasis Plan as much as in the personal interests of the IHS staff. In one Service Unit an excellent Community Physician Program was established; not because it was a tribal priority or an item in the Emphasis Plan, but because the doctor who implemented it was personally interested in doing so. This is not to assume that alternative priorities are unworthy, but rather that they are not the priorities established by the tribes or formally by IHS, and therefore accountability is difficult, if not impossible. These "hidden agendas" clearly undermine the rational planning process.

The one exception to this dichotomy was on the Papago reservation. The priorities and objectives of the Tribe, the Emphasis Plan, and the IHS staff were all in accord. The common objective was the improvement of the services--reduced waiting time and more respect for the consumers. They were in accord because there was a strong tribal body advising the SU. It set its priorities and then hired a SUD who shared those priorities.

The present system misleads tribes and Health Boards who are told that they can set policy and then find their expressions of concern are not being implemented, causing cynicism and frustration.

A comprehensive planning system would highlight the needs of the Indians and more realistically indicate how much power each level had and what controls were being exercised elsewhere in the system. By highlighting the needs, it would increase the possibility that persons at all levels of the system would be willing to accept recommendations for priorities based on rational planning. There is also a need for a better planning instrument at the SU and Area levels.

Recognizing these planning problems, the Health Program Systems Center (HPSC) in Tucson is in the process of developing a project called Health Program Functional Analysis. Its purpose is to apply systems analysis to "the definition of a health program mission and the determination of what functions must be performed by the program in order to accomplish the mission." 2/ This represents an effort to lay out systematically, particularly for tribal groups, the various components that make up the planning process in a health system such as IHS--planning input, development of

1/ See also the Sections on Outpatient Clinics and Alcoholism.

2/ IHS, Health Program Systems Center, Health Program Functional Analysis Project: Progress Report, by P. J. Deffenbaugh, Jr. Prepared for the IHS/ORD Intramural Review Group, May 6, 1973.

standards, choosing among alternative courses of action, resource acquisition, monitoring, evaluation, etc. Tribal groups and IHS staff would likely find this planning document a valuable assist in redesigning their planning process.

Finally, as demonstrated at Papago, the best way to insure tribal participation in the planning process is for the Tribe to develop a strong tribal health organization (see the Section on Three Tribal Models).

I. F. THE IHS BUDGET

1. The Budget Process

a. Funding

The IHS budget is prepared according to the format established for the federal budget process. Central responsibility for preparation of the federal budget is assigned to the Office of Management and Budget (OMB), which negotiates with each federal agency to prepare the entire federal budget which is submitted to Congress by the President. In the long negotiations to arrive at a mutually acceptable budget between IHS and HEW, and then between HEW and OMB, IHS is required to justify how it intends to allocate funds appropriated for its use. Within the constraints of the dollar amount it expects to be able to negotiate from HEW and then OMB, IHS prepares a budget broken down on a line item basis for each of the ten or so program services IHS expects to offer (direct care, contract care, mental health, Public Health Nursing, etc.). When IHS finally makes its presentation to Congress, it uses the same line item budget format to justify to Congress how it will expend the funds it receives.

However, when the budget is formally submitted to Congress and when Congress formally approves the IHS budget, the program activities are only broken down by four general line items: Patient Care, which includes funds to operate both inpatient and outpatient (ambulatory) services, including the IHS hospitals and health centers and contract care services; Field Health Services which includes dental care, sanitation, health education, public health nursing, field medical services, etc.; Construction for health facilities repair and maintenance, as well as building new facilities; and Program Management. No further line item breakout is provided in the budget, although budget for personnel, personnel benefits, travel, rent, communication, printing, supplies, and materials are itemized separately. Additionally, the total number of permanent positions, temporary positions, the average GS grade, and the average GS salary of the staff employed by IHS are also included.

When Congress decides to fund a special program that is not contained in the budget, Congress will include an "add-on" detailing the specific program and the amount of money that is being appropriated for it. Otherwise, although the budget presentation breaks out the funds, line item by line item, Congress's allocation does not make that distinction. Therefore, although the explanation is given by Dr. Johnson that he "feels

a moral commitment to expend the money for programs as Congress understood it would be expended when it appropriated the money," IHS Headquarters does have the legal prerogative to be extremely liberal in transfering funds from one Program Area to another (within the four general line items set out above) on its own or when a request is made by an AO. Headquarters has the right to establish more specific line items for administrative purposes and hold the AO's and SU's to them. As it now operates, the budget allocations go from Headquarters to the Area Offices, and from the Area Offices to the SU's, divided into separate specific line items, and firmly embedded in the requirement that the AO's and eventually the SU's must provide specific programs and staff based on that line item. But that is a Headquarters decision, not a requirement of the Congressional budgeting process. Only the new programs that have been added by Congress and construction are likely to be program and Area specific, having been so designated formally by Congress.

The specific budget categories or line items used by IHS are carry-overs from BIA days. They were developed by Congress and IHS as a matter of convenience, on an ad hoc basis, as new needs were identified and new programs established. The field staff felt that the use of these categories had been continued as a convenience and historical practice rather than with an intentional design by IHS or Congress to affect priority setting. IHS staff were also unclear whether anyone had ever tried to change it. In any case, a historical practice that has little to do with identifying needs or utilizing tribal input plays a major but questionable role in IHS priority-setting.

The decision as to how much money Congress should allocate to each line item is based on a number of factors. First IHS asks for sufficient funds to cover on-going programs and mandatory increases. It also indicates which line item categories warrant budget increases and how large an increase. According to IHS this decision is based on analysis of data and on input from the field--both IHS and tribal. However, the staff in the AO's felt that the decision was primarily a function of the personal philosophy of the Director of IHS, coupled with his interpretation of what Congress would buy, rather than the expressed needs of the Area or SU staff, or of the Indian people. This process was a source of extreme irritation to a number of Area staff persons.

Dr. Johnson felt that this criticism was not always valid, saying that Congress made the decision on these programs and in a sense offered it to IHS on a one-shot basis. IHS had the choice of accepting the funds for the purpose specified by Congress or not getting the extra money. In his view, Congress's decision was often based on testimony by tribal groups before Congress, and IHS itself had no control over the matter. But once Congress did provide funds for a specific purpose, he felt an obligation to preserve the fiscal integrity of the program and insure that

the funds were used only for the purposes for which they were allocated. A more comprehensive planning system involving the tribes would help to rationalize this process.

Indian tribes also impact the funding process. While there has not been much lobbying for the overall IHS programs by the tribes or Indian organizations, a number of tribes do request funds for particular local purposes. The North Dakota tribes obtained 34 additional doctors, and USET and the California Indian Health organizations also obtained funding this way.

Funding Increases

From 1971 to 1975 virtually all of the IHS budget increases have been for new programs or mandatory increases. The mandatory increases are to cover governmental pay raises and for funds to cover inflationary costs--increased cost of drugs, food supplies and most importantly, the increased costs for hospital and physician contract services. In the past few years new programs have been mainly those earmarked for specific locations such as communciations in Alaska, California Health Boards,etc. This has reduced the need for IHS to make new determinations on how it distributes the budget among the different AO's, since IHS allocates the base program to the Areas primarily on the basis of what they received last year.

A major concern expressed by IHS staff during the interviews was that IHS was receiving money and positions for new programs at the expense of the patient care programs. Yet except for mandatory increases due to increased costs almost all general additions to the budget have been in the areas of field services or outpatient services, and these additional funds since FY 71 have been very limited. The field services, other than field medical services (outpatient) have received about $15 million. The only other new monies coming into the system have been in the special Indian and tribal programs, CHR's, alcoholism, etc.--about $20 million--most of which came from the former President's special $10 million fund which was almost entirely drawn from funds budgeted to other federal programs.

Funding from Headquarters to Area Offices

IHS's first priority for funding allocation to the Areas is to continue the base (or existing) program. Therefore, initial allocations are made by Headquarters to the Areas mainly on the basis of the number of positions and dollars awarded to each Area during the previous fiscal year, with an effort to make some, albeit minor, adjustment for changing utilization patterns that might have occurred over the year from one Area to another. Headquarters does not break down the budget into SU allocations. It is the responsibility of the AD to distribute the funds among the SU's. This puts enormous pressure on the AD from the

competing interests of the SUD's and occasionally from the IHB's. Disputes that cannot be resolved between the SUD and the AD usually go to the IHS Director and are resolved at Headquarters. Some IHB's or tribes go directly to Congress, particularly if their Congressman or Senator is on the Sub-Committee on Indian Appropriations.

Funding by Headquarters to the Areas for new funding (general budget increases) is based on a variety of measures of need: morbidity and mortality data, average daily patient load (ADPL), and to some degree is based on negotiations between Headquarters and the AO's. Increases in funding for specific programs designed to treat certain health problems, such as mental health or otitis media, are distributed to Areas on the basis of planned programs developed by the AO's to treat the particular condition for which the monies were allocated. If there are not sufficient monies to fund the plans submitted by all the Areas, they are distributed among the Areas on a proportionate basis with consideration give to those Areas who have the highest prevalence of the particular health problem or condition.

b. Allocation of Position Slots

Allocation of funds under the budget is only one half of the problem. The budget also allocates the number of staff positions (slots) IHS is permitted to have. If IHS does not have a position slot it cannot have an employee even it if has the funds to pay him/her.

The number of IHS staff has changed very little since FY 71, when they were raised about 500 positions. Those positions were divided evenly between patient care and the Field Health Services.

The allocation of personnel slots may have at least as great or greater effect upon an SU's ability to provide a service. The easiest way to produce more service for the same amount of money is to utilize an increased number of paraprofessionals in the health field. Since salaries of paraprofessionals are considerably lower than for professionals, the ability to hire them may not be a matter of cost, but rather the limitation on the number of positions available to IHS.

Where there have been increases of positions for direct patient care, ambulatory care, mental health, etc., the distribution of these positions has been done in order to accomplish a comparable employee balance among all the Areas.

Headquarters allots the positions to the Area Offices, and the Area Offices in turn make allocations to the SUD's. Once the SUD gets the personnel slot from the Area, he has full

control over the position (it is not item-bound) but gaining one position at a time does not permit a reorganization of the SU work force based on a health team format. The SUD is still unable to make decisions based on consideration of the staff needed for the population to be served, the needs of that population, the amount of service to be delivered by direct care and the amount to be delivered by contract care. The addition of only one or two slots is not likely to be enough to permit a successful reorganization of the entire staff and he is therefore most likely to continue his staffing pattern as it has always been, adding the new staff either where it has been assigned or at best attempting to plug the increasing need in his outpatient and field services.

There has been a rise in utilization of outpatient and field services every year since 1956. Under the circumstances the present system of allocation of slots and funds based on the previous year's budget and the Service Unit that politics the hardest, makes little sense. As long as IHS continues to fund the AD by line item, there is little flexibility on the part of the SUD to determine how best to utilize his scarce resources. Since up to the present the SUD has not been able to decide for himself that, for instance, he would prefer to provide health education in combination with services provided by the Public Health Nurse, or by utilizing the CHR's to perform the function, and thereby release the one health education position to cover the cost of two community medics. This type of creative juggling has either been unavailable to him, or he has not perceived that he had the power to do it, or did not have the imagination to try it. Under any circumstances, at the SU level, staff allocations have been locked in; and without clear guidlines that spell out the SUD's authority to make changes, and enough new positions so that a total realignment of staff can produce results, it is unlikely that fundamental changes to deal with the crises in the clinics throughout the system are likely to occur.

2. The Evolution of IHS Budget and Staff Slot Problem 1/

In 1956 there were 2,909 IHS employees. There are now 6,257 employees, an increase of 115%. 2/ Since 1956 IHS hospital admissions have risen 63% but there has been an average daily patient load (ADPL) decrease of 44%. Contract care hospitals have had a drop in ADPL of 70%. In the meantime there has been an increase of 516% in the outpatient service and a 963% rise in patient home and field station visits. 3/

1/ Source of data - IHS records 1957 Study - Surgeon General's Office.

2/ Exclusive of Alaska.

3/ From 1964-1973. The definition shifted during the time period.

The funds available for services have increased 560% since 1956. 1/ Management costs have increased by only 89%, IHS hospital costs are up 327%; patient care other than hospital care has increased 627%.

The rise in administrative costs has been low considering inflation and the increased size of the program. Although the number of contract care patients served has decreased by almost 70% since 1956, more is being spent on contract care in 1974 than was spent in 1956 because of the rising costs of private hospital care. Although average daily census in the IHS hospital has gone from 2,663 in 1956 to 1,499 in 1973, a loss of 17.5%, the relative drop in share of the budget has been only 8%. On the other hand, outpatient services from facilities and clinics have increased from 540,860 in 1956 to 2,329,160 in 1973. With an increase of 331% in outpatient care, there is only a relatively small increase in the proportion of funds allocated to the service (6%). 2/ Clearly there is need to reallocate funds, but even more clearly there is a need for more funds.

3. Funding Shortages

IHS suffers from severe funding shortages in just about every area of operation. In 1972, IHS projected that in FY 1975 it would cost $178,000,000 to run the IHS program. Its present porjection is that it will cost at least $281,000,000 to run the 1975 program.

Though recognizing that the number of inpatient admissions has remained relatively static or even fallen while the number of OPD and field service visits continues to rise astronomically, IHS staff efforts still seem to be focused on the problem of inpatient care, rather than on the on-going problem of the outpatient crisis. Unlike the Indians who pinpoint the SU overload as one that must be dealt with, IHS staff have maintained that the load on the clinic services will be resolved through an eventual reduction in the need for services. The continuing rise in the morbidity rates suggests that this is not likely to occur for a long while (see Health Delivery System).

Other critical shortages exist in the system. Field health services are particularly short of training money, essential if they are to switch from individual service to the more productive community health team concept. A cost analysis of training is being undertaken (though some AD's who prefer visceral management to cost accounting are opposed). This is particularly important

1/ Exclusive of construction and so-called "new programs".

2/ Though some of the increase in outpatient visits has been for programs such as mental health which are paid for out of "add-ons" (i.e., new funds not included in this calculation).

if funds are to be found for wholesale upgrading of Indian staff.

Other programs appear to be well funded. IHS staff maintain that the dental program always gets good funding; they believe this is because the dental chiefs are good managers and make a good case for their program. Yet Dr. Johnson maintains that only 40% of the dental needs are being filled. Staff believe that Health Education is also in good shape and gets all its positions fully funded. Yet a study 1/ revealed that one-half of those funded positions had never been filled.

There is consensus that the Public Health Nursing Program (PHN) is extremely short of funds, staff, and staff positions. Along with several other programs, the PHN's have to scrape together operating funds by leaving unfilled positions vacant for several months longer than necessary. Money not spent on salaries becomes their operating funds. With the enormous need for increased PHN services, particularly as leaders of the community health teams, they should not have to make these kinds of cuts in service. While there are also problems finding PHN's, if adequate money were available, a program could be established to upgrade new Indian Registered Nurses or Community Health Medics to the PHN level.

4. The FY 75 Budget

In FY 74, IHS requested $177 million for all IHS services exclusive of construction. Congress appropriated $184 million. The FY 75 budget estimates that $193 million for Direct Care and Field Services will be expended in FY 74. (A $6.6 million supplemental funding is being requested for FY 74--$6.0 million in patient care and $0.6 million for field health services.)

The FY 75 budget is requesting $223 million for patient care and field health services, an expansion of $16.7 million for patient care and $8.8 million for field health services. These additional funds are to be utilized to support expanded levels of ambulatory care, contract health services and field medical services.

A proposed expansion of staff is also being requested for FY 75 from an estimated 7,751 persons employed during FY 74 to 8,063 in staff for FY 75. 560 new permanent positions 2/ and

1/ Cressap, McCormack and Paget (1972).

2/ From the level of IHS staff reported on HEW computer January 1974, plus IHS reported Commissioned Officers. See Section on Staffing.

$32 million offer a major opportunity to reexamine slot and funding allocation during the coming year. In light of this FY 75 Budget request, IHS must determine the most appropriate use of those slots and funds quite soon if it is to take full advantage of this opportunity.

At a time when there is no increase of funds or allocated positions it is virtually impossible to convert to a more flexible approach, but at the present time (assuming passage of the IHS FY 75 Budget) there will be both new money and new positions. These funds have been allocated to improve ambulatory service and expand contract care. Improved ambulatory service can be provided by greater use of health teams by increasing the number of paraprofessionals and technicians on the team. Also on many of the reservations there is a recognition that the CHR program needs major reconsideration and clearer objectives in order to make the CHR's more functional (and incidentally more satisfied with their own roles . See section on CHR.) With the short time available before the new positions and new money are locked into the same mold, each Area Office and SU should reexamine its own priorities to determine how best they can utilize the new funds and positions to improve their service delivery. Additional thought should be given as to whether the priorities established in the Emphasis Plans and the priorities of unmet needs stand up as being the most cost-effective, and the best allocation of new resources.

IHB's should examine the budget allocations and the position allocations to determine whether they should ask for a variance from Congress to permit a direct service delivery system to operate within its budget and not be held to a precise number of permanent positons. The decision to maintain a ceiling on the number of position slots is purely a political decision to avoid the appearance of a vast federal bureaucracy, but makes no sense in a direct service agency where the constraints of budget available for expenditure should not be compounded by the constraints of the number of staff. Thus if service can be performed more efficiently by assigning more people at a lower grade level at the same cost to the agency, there seems no rational reason not to obtain more health services for the Indians for the same expenditure of funds. 1/ The logic of position restrictions in IHS is hard to accept.

1/ This concept has been successfully tested. In 1970 the Department of Defense launched Project REFLEX (Resource Flexibility) in which a number of DOD agencies operated solely under financial controls, without manpower ceilings, so that management could adjust personnel levels to match work load requirements and available funds. A GAO study found the project a remarkable overall success. Among other benefits, "Management was allowed the flexibility of acquiring employees with appropriate skills and levels of experience and organizing them in balanced working groups to increase efficiency and production." Washington Star-News, June 28, 1974, page A-4.

Certainly within the frame of the 98,000 employees of HEW, the 8,000 persons working for the IHS (8% of HEW staff) are not enough to appreciably affect HEW's compliance with Civil Service decrees. In any case, Congress could, while placing its restriction on expenditures, agree to a variance on the number of permanent positions.

Temporary Formula For Allocation

The lack of a formula for allocating funds has not been of major concern with so little new money available in the recent past. With the FY 75 budget the issue takes on new importance. There was little evidence that Indian Health Boards became involved in the budget procedure that allocated funds from Headquarters to Areas. Indian involvement in allocation of funds or slots from AO to SU was also apparently unusual. Since the budget procedure is the key to all further decisions relating to the quality of service to Indians, clearly Indians have to take a more aggressive posture vis-a-vis budget allocations. Participation in developing and/or approving Emphasis Plans or establishing priorities on unmet needs is too late in the planning process and too peripheral to major budgetary concerns to permit Indian involvement to affect the critical issues of health services to Indians. Under the principle of Indian involvement, Indians should be involved in the major issues of funding allocation. An approach to a formula for allocation of funds Area by Area is an issue of interest to Indians. What happens to the money once it reaches the Area as it is distributed SU to SU is also of interest to them.

New methods are being investigated by HPSC and a Headquarters Task Force to develop a better allocation system. New procedures for allocation will include in the formula such things as the prevalence of specific kinds of diseases, amount of time patient spends with a doctor, time spent with a nurse, X-ray technician, etc. There are IHS reports going back several years indicating that a system was being developed to improve funding allocations, yet they are still studying the problem. Until ORD and the Headquarters Task Force studying the allocation problem come up with a recommendation, a formula could be developed that would permit Indians to make recommendations and participate rationally in the allocation decisions and procedures.

The emphasis in budget allocation should be on the needs of the patients served rather than on the performance or non-performance of an AO or SU. If on the basis of identified need, one Area is determined to be underfunded, because the needs of the patients are not being met, then on the basis of that need, Headquarters should offer the money to that Area Office, because of the need of the Indians, rather than on the basis of the ability

of the AD to use it wisely. In order to assure that the new funds are used well, a team from CRD (or other technical resource), a Task Force from the AO, and staff of the AIHB (or members if there are no staff) could work together to assist SU's in the Area to improve their utilization of not only the new money and new staff that have become available, but also to improve utilization of existing funds and staff. Clearly no Area can be expected to participate voluntarily in a plan to reduce its present level of funding, although certain Areas and SU's might be inclined to change voluntarily the way an SU is presently spending its money. However, starting with the base of what each Area and SU is presently receiving, a rationale can be developed for allocation of the new positions and the expanded funds. In doing so, the following issues might be considered (see Table on following page):

1. The service population of the Area

2. The degree to which that Area's services are presently being utilized.

3. The relative utilization of services in one Area compared to another Area.

4. The bed capacity within the Area, and the degree of utilization.

5. The present allocation of Contract Health Service relative to both bed capacity and bed utilization of IHS hospitals in the Area.

6. The present load on the outpatient services and the utilization of the field medical services including the services offered by the Public Health Nurses.

7. Those diseases that are either preventable or controllable that have a continuing high incidence among Area service populations should be ranked by rate of incidence. Those Areas that rank high could receive extra funding (see Health Delivery System).

8. Those Areas that have particular problems associated with great distances or particular isolation, such as Alaska or the Navajo Tribe should also be given extra funds since it takes more staff, more transportation, communications systems, etc. to work within that framework.

Once allocated to the Area, the Area should use similar indices to allocate positions and funds to the SU's. Again the issue should not be which SU in the past has most successfully utilized its funds, but rather which SU within the Area has the highest concentration of problems. At that point it should be the responsibility of AD staff, AIHB staff, and if necessary,

Table I-F-1

Percent of Total IHS Services Offered by Each Area Office
(FY 1973)

Area (or Sub-Area) Office	% of IHS Service Population	% of Staff	% of Bed Capacity	% Admission IHS Hospital	% of IHS ADPL 1/	% Money for Contract Care	% of out Patient Service
Aberdeen	9.5%	12.4%	15.7%	16.8%	12.3%	11.9%	13.6
Bemidiji	4.5	3.3	1.9	2.6	1.3	5.1	2.4
Alaska	10.8	17.7	18.9	15.0	20.8	12.0	9.6
Albuquerque	7.3	7.1	6.1	4.8	5.9	8.1	6.4
Billings	5.8	5.4	3.3	4.4	3.1	12.5	9.0
Navajo	19.4	20.6	20.8	23.8	24.2	9.9	21.5
Oklahoma	22.7	11.6	13.0	12.5	10.9	9.5	13.7
USET	2.1	1.7	2.3	2.2	1.7	3.0	2.6
Phoenix	10.7	14.8	16.1	15.9	18.0	13.9	14.0
Portland	5.4	2.6	None	None	-	12.9	5.6
Tucson	1.9	2.6	1.8	1.7	1.7	1.3	1.6

Source: Unpublished data from IHS.

1/ Average Daily Patient Load

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staff from the ORD (or other technical assistance) to assist the AO and the SU's to utilize the new funds as creatively as possible. Any plan for utilization of the new funds should also take into consideration the effectiveness of the programs already operating to determine whether the AO and/or the SU, within existing constraints, could improve its delivery of service to Indians. These decisions should certainly include Indian Boards and Indian staff, where they exist, to assure that new models, once established, are acceptable both from the point of view of Indian priorities and Indian values. Such factors should be included in the formula for both slots and monies.

I. G. STAFFING AND EMPLOYMENT ISSUES

In his Indian Message to Congress on July 8, 1970, the President pointed out that, "only 2.4% of HEW's Indian health programs are run by Indians." Recently, the Secretary of HEW stated that, "at the present time, more than 53% of the 7,142 full-time personnel of IHS are Indians and Alaska Natives. Many of these people have been trained in our special schools and courses conducted by IHS."1/

There is no conflict between the two statements, as each refers to a different problem. While the President was discussing control of the Indian Health Service programs by Indians in policy positions, the Secretary of HEW was referring to IHS as an employer of Indians at any grade level. The most recent data (April 1973), obtained from IHS for this report, essentially agree with the Secretary's figures: of 7,430 employees, 52% are Indians, but only 4.6% are at the GS 13-15 or equivalent Commissioned Officer level (see Staffing Summary, Table I-G-1).

Selected data on the employment situation in IHS are presented in the Summary which breaks down IHS staffing patterns to show from different perspectives where the Indians are in the agency--and where they are not. It provides the kind of specific information that would be useful to a Health Board or other group wishing to address itself to specific problems of Indian employment in IHS. The data were derived from the IHS computer printout covering April, 1973 figures.

One method of Indian self-determination in the health area is the employment of American Indians at the management and decision-making levels of IHS. However, this solution is infrequently utilized. Various problems in implementation have been cited, both by IHS staff and by Indians. Progress in placing Indians in significant IHS positions has been very slow. Without aggressive, well-organized action by Indians, their control of IHS key positions seems unlikely to occur for a long period of time.

1. Indian Employment at Various Levels of IHS

a. Headquarters

The overwhelming majority of the 3,858 Indian employees now in the Service are to be found in low GS and Wage Board levels, despite the fact that many of them were trained in special IHS schools and courses. Fifty-one percent of the 375 employees at

1/ Remarks by the Honorable Caspar W. Weinberger, Secretary of Health, Education, and Welfare, before the National Congress of American Indians, Tulsa, Oklahoma, October 30, 1973. (See Section on Training.)

Table I-G-1

All IHS Employees

Number and Percent Indian by Employment Classification

All GS Levels and Commissioned Officers

	G. S. Level					
	1 - 5	6 - 7	8 - 10	11 - 12	13 - 15	TOTAL
Non-Medical						
Professional						
# Indian	51	38	23	31	11	154
# Non-Indian	4	10	16	62	61	153
Total	55	48	39	93	72	307
% Indian	92.7	79.2	59.0	33.3	15.3	50.2
Technical						
# Indian	109	79	53	16	1	258
# Non-Indian	31	33	53	48	10	176
Total	140	112	106	64	11	434
% Indian	77.9	70.5	50.0	25.0	9.1	59.4
Clerical						
# Indian	757	67	20	39	5	888
# Non-Indian	205	78	16	17	40	356
Total	962	145	36	56	45	1,244
% Indian	78.7	46.2	55.6	69.6	11.1	71.4
Service						
# Indian	775	82	23	47	12	939
# Non-Indian	213	85	25	50	72	445
Total	988	167	48	97	84	1,384
% Indian	78.4	49.1	47.9	48.5	14.3	67.8
Summary						
# Indian	1,692	266	199	133	29	2,239
# Non-Indian	453	206	110	177	183	1,129
Total	2,145	472	229	310	212	3,368
% Indian	79.0	56.0	52.0	43.0	14.0	66.0
Medical						
Professional						
# Indian	12	94	73	19	6	204
# Non-Indian	35	461	283	108	65	952
Total	47	555	356	127	71	1,156
% Indian	25.5	16.9	20.5	15.0	8.5	17.6
Technical						
# Indian	379	71	12	3	---	465
# Non-Indian	44	105	58	33	16	256
Total	423	176	70	36	16	721
% Indian	89.6	40.3	17.1	8.3	---	64.5
Service						
# Indian	938	1	---	---	---	939
# Non-Indian	85	1	---	---	---	86
Total	1,023	2	---	---	---	1,025
% Indian	91.7	50.0	---	---	---	91.6
Summary						
# Indian	1,329	166	85	22	6	1,608
# Non-Indian	164	567	341	141	81	1,294
Total	1,493	733	426	163	87	2,902
% Indian	89.0	23.0	20.0	13.0	7.0	55.0
Commissioned Officers						
# Indian						11
# Non-Indian						1,149
Total						1,160
% Indian						0.9
Medical and Commissioned Officers						
# Indian	1,329	166	85	28	11	1,619
# Non-Indian	164	567	341	715	656	2,443
Total	1,493	733	426	743	667	4,062
% Indian	89.0	23.0	20.0	3.8	1.7	39.9
Total IHS Employees						
# Indian	3,021	423	204	161	40	3,858
# Non-Indian	617	773	451	892	839	3,572
Total	3,638	1,205	655	1,053	879	7,430
% Indian	83.0	35.0	31.1	15.3	4.6	51.9

Source: IHS Computer Run - April, 1973

IHS Headquarters in Rockville, Maryland, are Indians; 1/ but of the 77 GS-13's or above at Headquarters, only 13 (17%) are Indians. None of these 13 are in key decision-making positions. Saturating the lowest levels of the bureaucracy with Indians will not enable Indians to gain control or to effectively impact the management of IHS in the interest of their own people. The high percentage of Indians employed at Headquarters means little in the way of control, as very few of them occupy positions that offer access to policy-making roles.

Steps must be taken to correct this situation. Of the 13 Indians in GS 13-15 positions at Headquarters, at least some of them could be immediately upgraded with or without additional training into more influential positions. There are 155 Indian employees (13 at Headquarters) in GS 11-12 positions who could be prepared for support roles to top management (see Table I-G-2).

b. Area Offices

The recently appointed IHS Area Director at Billings is the only Indian presently holding this important field post. Previously the only Indian Area Director (now retired) was at the Oklahoma City AO. Of the key support positions of Deputy Area Director or Executive Officer, only two such posts are held by Indians. Since the Office of the Area Director exercises most of the decision-making authority in the Area, the absence of Indians in these positions severely diminishes the potential for Indian control. Many Indian Area staff specifically pointed out their non-Indian front office to the UAI interviewers. IHS Headquarters indicated that two more Indians are being considered for AD positions. This could represent the beginning of a positive shift. The results are still being awaited.

It might be expected that, proportionally, more Indians would be found in key positions in Area Offices than at Headquarters, on the assumption that Indians are starting to work their way up the ladder. However, six Area Offices have a lower overall percentage of Indians in GS 11 and 12 positions than does Headquarters. All Area Offices have a lower percentage of Indians in GS 13-15 positions than at Headquarters (see Table I-G-2).

A greater effort is needed to strengthen the position of Indians in the Area Offices. No Indian employee of IHS expressed the need to have Indians in key positions in the Area Offices to influence decisions made by the AD on hiring and on allocation of training

1/ Exclusive of Commissioned Officers (since there are only 11 Indian Commissioned Officers nationally, the CO's at Headquarters can be assumed to be nearly all non-Indians). The IHS computer run of April, 1973 has a total of 7,430 IHS employees; the HEW computer January, 1974 shows 7,506. The computer runs were utilized to show different information, which accounts for the occasional minor discrepancy.

Table I-G-2

Headquarters, Area Offices, and Service Units 1/

Number and Percent Employed
Indians and Non-Indians 2/
at the
GS 11-15 Level

	# Employed	# Employed Indians	% Indians
Headquarters	122	26	21%
Area Offices			
Aberdeen AO	31	3	10%
Service Units	44	13	30%
Bemidji	14	3	21%
Service Unit	6	0	0
Anchorage AO	50	7	14%
Service Units	48	5	10%
Albuquerque AO	26	7	27%
Service Units	17	3	18%
Billings AO	23	0	0%
Service Units	28	8	29%
Navajo AO	22	7	32%
Service Units	53	11	21%
Oklahoma AO	34	16	47%
Service Units	34	16	47%
USET PO 3/	4	3	75%
Service Unit	8	5	63%
Phoenix AO	29	3	10%
Service Units	44	7	16%
Portland AO	12	1	8%
Service Units	19	8	42%
Tucson PO	45	4	9%
Service Units	17	1	6%
Total	608	131	

Sources: HEW Computer Run - Jan. 1974.
Tucson - IHS Computer Run - April, 1973

1/ Based on 69 reported S.U.

2/ Exclusive of the 1,160 Commissioned Officers.

3/ Program Office

funds. Of 40 persons employed as Area personnel officers, only eight are Indians and only one is at the GS 11-12 level, compared to 32 non-Indians, of whom 27 are at that level.

Only in the Oklahoma City Area, where there was an Indian AD until his retirement last year, is there evidence of a commitment to Indian employment, not only at the service and para-professional level, where 78% of the Area employees are Indian, but also in decision-making positions, where there are 47% Indians at the GS 11-15 level. The Director established a rule that no non-Indian could be hired until IHS had made every effort to recruit an Indian. In this case at least, an Indian in a key staff position resulted in increased Indian employment (see Table I-G-2).

Many feel that it should be the responsibility of the Area Indian Health Boards (AIHB's) to serve as advocates for Indian preference, but Indian staff complain that most Boards have taken no strong positions on the subject of Indian employment.

c. Service Units

Some indications of change are beginning to be evident at the Service Unit level. Exceptional efforts are being made to place Indians as Service Unit Directors (SUD's), with 15 of the 84 SU's now having Indian Directors. By far the best record of Indian employment can be seen in the SU's in the Oklahoma City Area and in the United Southeastern Tribes (USET) sub-region, where a relationship to the tribes through contracting has made IHS staff positions clearly dependent upon tribal approval (see Table I-G-3).

Indians are absent or nearly so in the upper grade levels of some other SU's. The Phoneix Area has three SU's with no Indians at the GS 11-15 level; Aberdeen and Albuquerque each have one SU that has no Indians at this level; the Tucson SU records only one Indian (see Table I-G-2).

The arguments against placing Indians in policy and decision-making positions given by IHS staff are many-faceted: qualified Indians cannot be found; Indians in decision-making positions are a threat to non-Indians in IHS; Civil Service job requirements impede IHS's efforts to foster Indian control within the agency. IHS staff claim that if qualified Indians could be found, they would be hired. It is further claimed by IHS Area Office staff that, in the absence of such qualified applicants, Indians are often hired anyway, just because they are Indians and not because they are qualified to do the work. This attitude concerns IHS non-Indian employees, who view any strong stance on Indian preference as lowering the quality of IHS. The agency has only begun to deal with this problem.

By placing non-Indians in top positions, IHS has fostered paternalism. The non-Indians, fearful of losing their own high-grade jobs, are not anxious to find Indians to replace themselves.

Table I-G-3

Service Units (69) 1/

Percent of all Employees who are Indian 2/

Area Offices	20-29%	30-39%	40-49%	50-59%	60-69%	70-79%	80-89%	90-99%
Aberdeen					5	5		
(Bemidji)				1	1	1	1	
Alaska			2	1	1	4		
Albuquerque				1	1	3	1	
Billings				1	3	1	1	
Navajo					1	4	3	1
Oklahoma					1	6	1	
(USET)*				1	1	1	1	
Phoenix			1		2	5	1	
Portland	1				2	1		
Tucson* 3/		1						
Total	1	1	3	5	18	31	9	1

Source: HEW Computer Run - Jan. 1974.

1/69 of the largest among the 84 Service Units.

2/ Exclusive of the 1,160 Commissioned Officers.

3/ IHS Computer Run - April, 1973

* Program Office

In Areas such as Portland, with only 29% Indians in GS 11-15 positions in both the AO and the SU's, or Billings, where the figure is only 16%, the intense dislike for Indian preference in employment was clearly evident during our field interviews. Non-Indians saw any policy to give Indians preference as a threat to their jobs. Thus, Indian control and involvement becomes a personal career issue, rather than the mandated right of Indians or a philosophic adherence to a principle, and progress becomes stalemated by the attitudes of many IHS non-Indian staff.

2. Equal Employment Opportunity Enforcement

Equal Employment Opportunity (EEO) officers are stationed at IHS Headquarters and at each Area Office. Most EEO officers, themselves Indians, are sincerely committed to the achievement of Indian control and self-determination in IHS through equal employment practices. However, most of the officers interviewed feel that the EEO program is floundering for lack of direct response to their complaints and support for their positions, from either the AD's or IHS Headquarters, even though the AD's are seen as sympathetic. Since the EEO officers have no power over Supervisors or Branch Chiefs, they feel the need for strong support of Indian preference from key personnel and Indian Health Boards (see Table I-G-4). They feel that if support were more visible, some of the non-Indian complaints would stop, since equal employment would then be accepted as a fact and opposition would gradually cease. The Commissioned Corps, which has the lowest level of Indian representation in IHS, produces the most resistence to Indian preference, according to EEO officers. (Only 11 of the 1,160 PHS Commissioned Officers in IHS have been identified as Indian.)

3. Recruitment

IHS has been intensifying its recruitment efforts to attract Indians to health careers in general and IHS in particular. Much of the work is being done at the high school level, where students start to make their career decisions. One IHS complaint is that the BIA high schools which many Indian attend have such weak science programs that their graduates are unprepared for further training in the health field. Indian EEO officers claim that another factor discouraging Indian youth from selecting health as a career is the negative attitude towards Indians, expressed overtly and covertly by IHS local personnel. Without unequivocal signals to the contrary from the top levels of the agency, this expressed attitude is likely to continue. Also, given the Indian/non-Indian hostilities over Indian preference and control, Indian staff in the Area Offices frequently questioned whether they were doing Indians a favor recruiting them for IHS. However, in such areas as United Southeastern Tribes (USET), where there is a strong Indian Health Program and a firm commitment to Indian involvement, hostile attitudes

Table I-G-4

Indian Health Service

Summary of Professional and Administrative Positions Held by Indians

(Civil Service and Commissioned Officers)

Positions	Number
Hospital directors	4
Medical officers	2
Community development specialists	21
Area directors	1
Area deputy directors	2
Social workers	7
Administrative officers	10
Nursing	13
Public health educators	4
Public health advisors	3
Human resources development specialists	4
EEO officers	8
Personnel management	3
Construction personnel	7
Program analysts	2
General services personnel	7
Indian health advisors	1
Tribal affairs officers	10
Budget analysts	6
Service unit directors	15
Staff assistants	5
Medical technology consultants	1
Hospital administrators	2
Illustrator	1
Sanitarians	9
Contract health care officers	2
Total	150

Source: House hearings, FY '74, p. 16. Information provided by IHS; no grade levels or comparable data for non-Indians were provided.

are nowhere near as great, and Indian staff are much more enthusiastic about recruiting Indians for programs.

Many IHS vacancies are announced for local consideration only, which means that only local applicants will be considered. Although IHS staff claim this is because Indian tribes prefer an Anglo to an Indian from another tribe, no confirmation of this could be obtained. Several EEO officers denied such a problem, citing Indians from other tribes who were employed successfully at t BIA Area or local Office. When a vacancy is announced as Area-wide, it means that only applicants from that IHS Area jurisdiction will be considered. In only a few cases, mainly hiring for IHS Central Office positions,does IHS announce a U.S.-wide applicant consideration. Also, IHS does not keep a list of potential Indian applicants with health background; so that each time a vacancy occurs that cannot be filled internally by an Indian, the staff must start from scratch looking for a non-IHS Indian. Because of the delay, pressure starts to build up to fill the vacancy and often the position is given to a non-Indian.

Proposals that Headquarters take the lead in a nationwide recruitment effort have been made by many Indian staff, at both Area and SU levels. It has been suggested that two registers, both placed on computers at Headquarters, be established. The first would list all present IHS staff members qualified for up-grading, identifying whether they are Indian or non-Indian, present job classification, GS rating, positions for which they indicated qualifications and interest, and geographic areas in which they would be willing to serve. Their knowledge and familiarity with tribal customs and culture would also be included and considered as a factor in qualifying for a position. Those interested in further training in order to qualify for upgrading would also be listed. Any staff person could request counseling to help determine what jobs he/she could qualify for, and what training might be available for upgrading.

SUD's, Branch Chiefs, and Headquarters staff in a position to hire, or persons seeking individuals for training opportunities, would have to consult this employee printout before considering any other applicants. In all cases, Indians would have first preference for jobs and/or training opportunities for which they could qualify.

The second list would be compiled of Indians interested in obtaining employment with IHS, their qualifications, and the jobs and Areas for which they would like to be considered. Only after these two printouts had been fully explored, and it was determined that no qualified or qualifiable Indian were available, could anyone other than an Indian be selected.

4. Indian Employment in Contract Care

If little is happening in IHS facilities concerning Indian employment, virtually no effort to employ Indians is being carried out at IHS contract health care facilities, according to IHS Indian staff. Although most contracts between IHS Area Offices and contract facilities examined for this study contained equal employment requirements, few of the contracts with physicians and other health professionals even mentioned such requirements. In its Congressional testimony, IHS maintains that 80% of all Indians employed in health occupations are employed by the IHS, yet one-third of all IHS funds are in contract care services. 1/ This means a third of the IHS budget goes primarily to employ non-Indians in private facilities. Contract officers maintain that while they can encourage contractors to give Indians preference, they cannot mandate it.

Employment of Indians on IHS contracts with private constructions companies that contract to build IHS facilities, such as hospitals and sewage systems, is also involved. The issue was discussed with contract officers from the perspective of (1) Indian preference, (2) Executive Order 11246 requiring employment of minorities on contracts using federal money, and (3) Title VI of the 1964 Civil Rights Act. Federal Law (25 USC 47) specifically mandates employment of Indians on jobs involving contracts with the BIA or IHS. The Executive Order and Title VI both require employment of minorities on federally-funded contracts and construction contracts--at least in proportion to the presence of the minority group in the labor market area (on the reservation, 90% or more). With Indians constituting a major part of the population on reservations, these provisions would also support action by IHS to require private contractors to give preferential employment to Indians.

However, the IHS has no national policy on this aspect of Indian employment nor does the Office of Civil Rights (HEW). One contract officer claimed that he had been trying to get a legal opinion on this from the HEW General Counsel for about three years, but had received no response.

The Office of Civil Rights, in conjunction with its Indian Advisory Group, is now preparing regulations that would mandate preferential employment of Indians on all HEW-funded projects on Indian reservations. When these regulations are implemented, IHS contract officers will have the necessary vehicle and the legal requirements to ensure that any private company with whom IHS contracts gives Indians preferential employment. Tribes should monitor IHS practices in construction contracts to

1/ And this does not take into consideration employment of Indians living in the 26 states not in IHS's service areas, or those employed in urban areas in the 24 states.

ensure Indians are receiving their preferential employment rights.

5. HEW and Indian Employment

The absence of Indians in IHS policy positions also prevails in the whole Department of Health, Education and Welfare. Only 246 or 0.3% 1/ Indians are employed in DHEW outside of HSMHA; only 20 or 0.2% at the GS 13-15 levels; and only one or 0.2% at the 16-18 level. 2/ Under the circumstances, Indians have received much less from DHEW than from IHS.

1/ HSMHA includes IHS. 3.2% of all HEW employees including IHS, 0.39% excluding IHS.

2/ DHEW computer run, June, 1973.

I. H. TRAINING PROGRAMS

Training is the best resource available to assure that Indians are equipped to take over the key positions in IHS. Most IHS training is done at the Desert Willow Training Center, Tucson, Arizona; the IHS Training Centers; the Regional Medical Centers; and outside training at colleges and universities.

Desert Willow and the training centers provide short-term training to IHS employees, tribal employees, and Health Boards. They sometimes initiate these training programs on their own, but prefer to respond to requests for training made by the SUD, the AO, and the tribal Boards. Many Boards do not realize such a training resource is available to them. Desert Willow said they have enough demand for other short-term training and therefore do not make an effort to seek out Boards for training requests. As a result they have worked with only three SU's and one AO board, an obviously limited effort considering the great need for training among the IHB's.

Desert Willow feels that it has a well-developed, long-term training system for such positions as social worker associates, mental health associates, etc. Most long-term training available outside of the IHS centers is designed for professionals. The Center has a long-term training budget established by the Director of IHS. Decisions on its utilization are made by the Long-Term Training Committee, composed of the AD's, which regularizes long-term training as opposed to the admitted chaotic conditions to be found in short-term training (see Problems in Training, at end of this Section).

Interviews with IHS staff reflect a feeling that, in the past, the training offered was of two kinds: relatively low-level training for Indians, and relatively skilled or professional training for whites. The major exception was the management trainee program designed apparently, but not necessarily, for Indians. Some breakthroughs are occurring, however, including the Administrative Officer training program and the Master of Public Health Program at Berkeley.

IHS training is described in this section under three general categories: training offered at relatively low levels, such as the Upward Mobility Program, Project Start, or training for Community Health Representatives; technical level training in medical occupations; and training offered at the professional level, both in the medical and management areas.

1. Lower Level Training

a. Upward Mobility Program

IHS policy is now to encourage staff development and training for lower level staff through the Upward Mobility Program which provides training for IHS personnel at the GS 1-7 and wage grade equivalents, two-thirds of whom are Indian. Such lower grade jobs are mainly clerical and labor jobs requiring skills that can be acquired in a relatively short training period. The training is provided at Desert Willow and at local IHS sites.

A second program, START, now being developed, is aimed at the GS 1-5 grade level as a feeder into the Upward Mobility Program Desert Willow is examining and predicting vacancies in GS 7-9 positions,and expects to train GS 1-5's to fill them. Both START and Desert Willow Upward Mobility are two-year preceptor programs. The trainee receives several weeks of classroom training at Desert Willow, and then receives continued on-site training while back at his regular job from a higher level IHS employee who has proficiency in the skills the trainee is developing. When an employee completes the course, his or her name and skills go into the skills bank. Although the graduate is supposed to be placed first in all appropriate openings, there is no system to accomplish this. The two long-term programs: Upward Mobility and START are expected to replace some of the short-term training still being offered by Desert Willow.

b. Training for Community Health Representatives 1/

All basic training for IHS Community Health Representatives (CHR's) is provided by the Desert Willow Training Center. The four-week training course for CHR's emphasizes four areas: (1) communication skills and techniques; (2) socio-cultural concepts; (3) concepts of health and disease; and (4) technical skills. 2/

There is rising concern among Indians and IHS staff that the initial training received at Desert Willow is insufficient to enable CHR's to perform effectively in their local areas. CHR's, CHR Coordinators, Indian tribes, and IHS staff recognized

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1/ See Section on CHR's.

2/ U.S. Indian Health Servide, HSMHA, HEW, "Community Health Representative; A Changing Philosophy of Indian Involvement" (no date)

a great need for additional field or on-site training to equip CHR's with techniques for performing the functions described (albeit sketchily) in their contracts. Originally, CHR's were to be given an additional six weeks of field training, but no system was ever developed to bring about this needed training. Without field training or any further supportive activities, CHR's have a feeling of being dumped out in the field and then forgotten. About 1,500 CHR's have been trained, but many are dropping out because, among other reasons, their lack of field training leaves them without the skills or sense of direction that make their jobs satisfying. Also, there are few chances for up-grading and their salary is not competitive with IHS paraprofessional staff. However, according to the Desert Willow CHR training staff, this year the staff has finally started to do some field training.

IHS is also beginning to broaden the kinds of training available for CHR's; training them for an expanded role in health skills and in such areas as contract negotiations and monitoring the national reporting system. CHR's feel that if they are truly able to define their own roles, they have to have the power to shape their own training programs.

Another unresolved issue is who should conduct the new training--the tribes, Desert Willow, the AO's, or some other party such as the NIHB, AIHB, or an Indian training organization. Since the CHR training funds are all concentrated in Desert Willow, it makes it difficult for an individual tribe or Area to obtian resources to define and carry out its own CHR training.

However, as discussed in the CHR section below, most CHR programs must first shape their roles and work out the nature of their relationships with the tribes and with IHS. Until the roles of CHR's are more clearly defined, the issue of their training will not be resolved. The roles they are expected to play will measurably affect the design of appropriate training, where training should be provided and by whom. While there is merit in Desert Willow continuing to serve as a centralized training center for CHR's, certain tribes and CHR's indicated they would prefer to receive the funds and do their own training locally; they should have the option of doing so.

2. Technical Training

IHS has long trained persons for technical occupations in its hospitals, clinics, and elsewhere in its Service Units.

IHS has a continuing demand for technical personnel at the GS 7-9 level. The rate of employment of Indian staff is much lower at every level in medical than in non-medical occupations (see section on Staffing). It would appear that increased emphasis on training at this grade level would meet both IHS's need for more technical staff and the Indians' need for better jobs and mobility in the IHS hierarchy. In addition to training for the technician and technologist occupations, IHS has started programs in certain new technical occupations:

a. Community Medics

IHS has undertaken a small, but highly successful Community Medic program designed to graduate medics who can function independently in field stations or in conjunction with doctors in outpatient clinics. Additionally, community health aides are being trained to serve isolated Alaska Native villages too small to utilize a full-time doctor. A much expanded program is needed if the medics are to provide a means of meeting the doctor shortage, particularly to ease the excessive load that so pressures the doctors in the SU outpatient clinics.

b. Mental Health Technicians

Training leading to an AA degree for mental health technicians is offered at the Desert Willow Training Center. After several weeks' training at Desert Willow, enrollees return to their field stations, where they work under an IHS staff person or a contract psychiatrist in a preceptor relationship. The technicians, who are therapists in their own right, do marriage counseling, work with youth, etc. Desert Willow provides this training to tribal as well as to IHS personnel. IHS staff feels that this will be a more successful program than the CHR training, because personnel receive on-going training as opposed to the one-shot training provided the CHR's. Also, there is a career ladder for mental health technicians, who can work their way up to GS-6 and a salary almost twice what a CHR earns. The technicians acquire the foundation to move into new fields, e.g., use their AA degree as a basis for getting a B.A. in psychology, etc., and they learn skills that will be useful in acquiring other jobs,unlike CHR's, whose skills are not likely to be convertible into positions covered by Civil Service classifications.

Although useful and imaginative, the IHS program for training medical technicians is too small and fragmented to meet even the internal manpower needs of IHS, much less prepare people to work in third-party contract offices or in hospitals and facilities near the reservation. HMO's and other group

medical and dental practices offer considerable data to indicate that the quickest and cheapest way to expand services is to increase the number of technicians working as a team with doctors and dentists. Although the freeze on the number of positions in IHS affects this model, its basic validity and its usefulness to Indians, who can more rapidly be trained for technical than for professional occupations, makes increased technical training of Indians very attractive.

3. Professional Medical Training

Relatively few Indians or Alaska Natives are employed in professional health positions as RN's, doctors or dentists. If Indians are to become less reliant on an Anglo-dominated IHS, the most serious problem to be overcome has been, and will continue to be, an absence of Indian health professionals to start filling the void.

a. Nursing Program

While most practical nurses are Indians or Alaska Natives, only a few of the professional nurses are. While IHS has been training LPN's for technical and paraprofessional roles for some time, the training of RN's at the Regional Medical Centers and Training Centers is relatively new.

IHS has LPN schools at Albuquerque, Shiprock, and Rapid City, where they are not only training LPN's,but are also upgrading LPN's into RN's, using local colleges and universities for the academic portion of the training. There is a small fund to bring SU-based LPN's into the Training Centers or Regional Medical Centers on a regular basis to acquire their RN degrees, but no alternative schemes have been developed at rural SU's, using correspondence materials from the colleges to permit LPN's to acquire academic training, and utilizing PHN's employed at the SU's to provide the necessary preceptor support. However, IHS is working with the University of South Dakota School of Nursing and community colleges at the Rosebud and Pine Ridge Reservations on both pre-nursing and nursing programs that include an accredited RN program under the auspices of the university. IHS has still established no overall goals to train a given number of RN's per year throughout the IHS.

Since the nursing staff, the largest single classification of IHS employees, is as essential as the doctors in making IHS independent of Anglo professional resources, greater effort to upgrade Indian LPN's is clearly warranted.

b. Physicians' Training

Only three Indian physicians are presently employed by IHS among the 42 Indian physicians in the country. The National Medical Fellowships, Inc. provides up to 70% of the funds necessary to train minority first- and second-year medical students (including Indians) in the belief that these are the critical years when such encouragement is needed. However, where these students are to obtain tuition and living costs during the third and fourth years is a question left unanswered. Since there are no medical schools in reservation areas, Indians, unlike most minority medical students who are urban dwellers, have heavy living costs as well as tuition to consider. Also, the competition for such funds is intense and Indians are the least likely of minority groups to be aware of the resources available.

It takes 10 years to train Indian doctors, the key personnel in any medical service system. IHS claims that there are now 68 Indian students in medical training--a start in the long process. A medical school culturally oriented to Indian health needs is needed (and is in the planning stages). 1/ In the meantime, one solution would be for IHS to establish a crash training program for professionals by allocating scholarship funds to train Indian doctors, dentists, RN's and other health professionals. Such funds need not necessarily be new funds. They could be earmarked specifically for Indians from allocations for scholarship funds already appropriated to Higher Education or through the Bureau of Health Manpower Education (BHME) funds. (Even Dr. Johnson claimed in federal testimony that he found it difficult to locate, aggregate, and commit such funds for a worthy Indian medical student in whom he was interested.)

Financial support should be adequate to cover the full costs of Indian professional training. Indians are poor, have large families, and marry early. They are unlikely to be able to obtain funds from other sources if the federal government is unwilling to subsidize their training. 2/

In return for a fully paid scholarship, any Indian student accepting the funds would commit himself to work on his reservation or in any other IHS facility for one year for every year he/she utilizes the scholarship. Thus, if a student attended three years and then dropped out, he would still be required to spend three years working on the reservation in a health-related occupation. Funds should be made available on a

1/ See Section on Navajo Health Authority

2/ Such funds in part would be available under the Jackson Bill, S. 2938.

competitive basis, AO by AO, to assure that there would be adequate representation, tribe by tribe and SU by SU.

4. Management Training Programs

IHS's most comprehensive effort to train professionals is a new two-year program initiated by Desert Willow to train Administrative Management Officers.

Desert Willow and IHS Headquarters concluded that persons being hired as SUD's or Administrative Officers at the SU's, even those who had completed a Master of Health Administration that IHS was funding at several universities, were unprepared for the unique demands made upon them at the SU. For that reason, IHS created its own Administrative Officer's training program. The trainees, all IHS employees, will receive periodic classroom training for several weeks at a time at Desert Willow, plus on-the-job training back at the SU or AO, under the guidance of a preceptor. The course is designed specifically for the kinds of tasks an IHS Administrative Officer performs, including health law, budgeting, comparative health delivery systems, personnel management, etc. Upon completion of training, the graduate will receive an AA degree (granted by a local community college through Desert Willow). Trainees will be selected primarily on the basis of a determination by IHS officials that they have management potential. Because there are no formal educational prerequisites for this course, IHS says it will enable an IHS employee to go from a GS-2 to a GS-15 without having to take off for several years to earn a college degree.

During the two years of training, trainees will remain employed at their existing IHS job. As vacancies open for administrative jobs, trainees will be ready to move into them. Since an average of 20 managerial positions open each year at the SU level, the program is designed to produce 20 trainees a year. If the 20 positions do open as expected, this arrangement will avoid one of the major problems of training programs--lack of job vacancies when the course is completed.

Since the program is just beginning, no decision has been reached about using it to train Indians for the many more administrative positions available at the Area Offices or Headquarters. The program would also be an excellent one to train Indians to run their tribal health departments as they develop. Desert Willow staff said they had no immediate plans to use the program for this purpose, apparently because the number of tribes who have established tribal health departments have been too few to warrant offering the program.

IHS has had an on-going management intern program, but the AO administration (the AD and his deputies), has not provided enough management intern training slots to qualify enough Indians for management positions. Since an Area has to find its own funds in its budget for a management intern program, not all Area Offices have participated in the program.

Other management-related programs are offered by IHS. A Health Management Program for IHS employees provides a two-week series of sequential workshops on management concepts, supervision, public health, community development, and communications Although this program has also been offered to tribal leaders, Boards, etc., so far, Desert Willow has had few requests from these groups.

5. Training Program Problems

On most Indian reservations, the IHS Service Unit is a major employer of Indians, and, in many Areas, it is the largest single employer of Indians. Under the circumstances, the current IHS health manpower training programs are too few and too scattered, and those specifically designed for Indians are for positions too low in the hierarchy. The IHS training program lacks an overall strategy, is too centralized, and lacks a commitment to the principle of utilizing training money to train Indians. There have been no comprehensive evaluations of the training system to determine its value to its trainees.

The short-term training fund allocation system in IHS is particularly confusing and organized in such a way as to guarantee jealousy and discontent. Best organized are those specific service areas that have separate line item allocations in their budget for training (Nursing, Dental, Health Education, etc.) and therefore receive the most short-term training. Field clinic and hospital care, which do not have a training budget, are required to take money off the top of their budgets for training. The result is a wide variance from AO to AO as to the amount of funds available to invest in training. 1/ The major demand for training funds is from the doctors in the SU's, who feel isolated from new medical developments and want short-term training to keep up-to-date professionally. 2/ As reported by the AO staff, the majority of the IHS training money above the level of the Upward Mobility Program goes to training whites, mainly those already in professional classifications. Since there is no system for allocating training money, decisions on training are left, by and large, to the

1/ Cressap, McCormack and Paget.

2/ The Jackson Bill on Indian Health proposes new separate funding for short-term IHS physician training.

Branch Chiefs, who seem to operate by responding to those who complain the loudest and have the greatest access, rather than considering the greatest need.

Everywhere, complaints were registered as to how training decisions are made. Each SU has a training committee, which refers its recommendations to the SUD. The SUD then brings them to the Area training office, which reviews them for budget and mission orientation, not necessarily to determine their validity for assisting Indians to become upwardly mobile or on the basis of IHS's needs. From the Area Training Officer,requests go to the Executive Officer and the AD for final decision-making. Since the EEO officer reports directly to the Executive Officer, this makes it difficult for the EEO Officer to involve the AD to assure that training funds are made available to Indians rather than to non-Indians. One EEO officer stated, "The speeches of the AD are excellent," (in his commitment to train Indians)," but there has been little follow-up, so far, on his speeches, and it is difficult to reach him."

This situation has embittered the EEO officers who feel that, until the NIHB and the AIHB's get involved, few changes are likely to occur, although they are not very sanguine as to the likelihood of that occurring. Only in that way, they believe, will many of the Area Offices cease to be aggressively white.

There is also little training of tribal personnel to prepare them to run tribal health departments, even though this is one of IHS's stated goals. Many IHS management employees blame this situation on lack of funds and believe that training funds will have to be obtained from the already limited health delivery funds of the IHS budget if this is to be accomplished.

If IHS accepts the belief that an Indian who is either qualified or qualifiable for up-grading should be assisted to move into a decision-making position, there are specific steps it could take. There are Indians in a variety of administratiave positions already--EEO Officers, Tribal Affairs Officers, SUD's. Of all IHS employees at GS 11-15 level, 30% are Indians, 26% of these in Headquarters. Indians with potential should be identified and a training program undertaken to groom them for decision-making positions. This would require an evaluation of every Indian working for IHS at or above the level of GS-11. In order to assure that Indian values are included, members of NIHB, AIHB, and/or other Indians knowledgeable about the IHS program could be added to the Task Force.

Secondly, there is a need for a national IHS training plan, with greater control at the national level to assure overall goals and to determine a general allocation of resources. Then, each AD in consultation with critical personnel--SUD's, Training Officers, EEO officers and Tribal Boards--would develop a training plan for his Area, taking into consideration the relative costs of

training presently being provided. Headquarters should provide leadership in establishing a cost-accounting system to determine the cost of training. Cressap, McCormack, and Paget project a cost of $1,000 per employee for training. 1/ Whether IHS is obtaining $1,000 worth of value per present employee from its training programs is clearly open to question.

1/ Cressap, McCormick and Paget.

II. INDIAN INVOLVEMENT

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After a hundred years of living under an alien, often paternalistic government, Indian tribes and individuals are beginning to take control over the programs that affect their lives, including health, and to shape them to be responsive to Indian needs and Indian values. Tribal groups are developing a wide variety of methods for Indian involvement in, and control over, their health delivery system. Among these methods are: Health Boards at the Service Unit, Area Office, and national level; tribal health departments and authorities; tribally operated health programs; consumer evaluations; and inter-tribal health organizations. The Indian Health Service is publicly committed to supporting greater Indian participation and to developing methods for achieving Indian self-determination. It has developed a philosophy, committed resources, and created an administrative structure within IHS designed to support Indians in their effort to control the delivery of health services.

The most important issue identified by tribal leaders during interviews for this study was their need for a better understanding of how the present efforts toward self-determination could work for their benefit. This section describes in detail the two components of the process for increased Indian involvement: tribal structures and the IHS structure. The evolution of IHS policy on Indian involvement is traced, and the administrative structure established within IHS to promote Indian involvement is reviewed. The different mechanisms available to tribal groups to obtain greater participation in the health system--Health Boards, health departments, the CHR program, and contracting--are discussed. The section describes some existing programs that tribes could use as points of reference in structuring their own programs.

A. EVOLUTION OF POLICY

When IHS began its HEW program operation in 1955, token efforts were made to involve Indians in health programs. A study of IHS made in 1957 1/ by the Surgeon General alluded to the fact that Indian participation in the planning stages was a desirable objective for IHS. But, since there was no

1/ U.S. Public Health Service, HEW, "Health Services for American Indians," PHS Publication No. 531, February 11, 1957.

general or specific plan on how IHS could effect Indian involvement, and the Transfer Act legislation lacked direction as to how it was to be accomplished, Indian involvement policies have evolved over time on an ad hoc basis out of the IHS program itself. No legislative or executive mandate was issued to IHS to assure Indian involvement until the Presidential Message of 1970, which emphasized the theme of "self-determination without termination." 1/ This Message was an expression of Nixon's viewpoint on the state of Indian affairs, rather than an operational plan under which all federal agencies were mandated to proceed. Congress has not passed any legislation that would give the agencies the specific authority, tools, and resources they need to carry out a program of Indian self-determination. The result has been a disorganized federal approach to Indian self-determination, without the necessary policies, written guidelines, or resources to enable the concept espoused in Nixon's Message to become a viable reality for the Indian people. 2/

As a result, IHS has been left to develop its own policy for self-determination. That part of the IHS policy that has been put into writing appears primarily in Congressional testimony and in the IHS Operational Planning and Forward Planning Documents. The reasons stated by IHS for promoting involvement as part of its primary function of operating health programs are twofold:

1. Involvement to assume responsibility. The survival of any society is dependent upon the human necessity for self-identity and the working out of one's own destiny. Individual Indians as well as tribal groups have recognized this need, and are insisting on being heard and in having a voice in determining their future.

2. Involvement is essential for an efficient and effective health program, designed to meet Indian needs. 3/

Since few tribes or Indians have had experience in the health field, IHS's approach has been to first assist tribes to develop

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1/ Former President Nixon's Message Transmitting Recommendation for Indian Policy, to House of Representatives, 91st Congress, 2d Session, Document No. 91-363, July 8, 1970.

2/ S1017, "The Jackson Self Determination Bill" is directed to meeting these needs.

3/ IHS Manual

an individual capacity and a tribal mechanism for involvement in health, i.e.:

> "... The Indian people are becoming increasingly involved in health program functions in varying degrees, from the provision of physical facilities for health activities to the establishment of tribal health boards charged with the policy-making responsibilities for the programs. The capabilities for doing these things are clearly not inherent in the tribal organizations or the self-government experience of the Indians, but rather must be nurtured and encouraged in such a manner as to make maximum utilization of those abilities and capabilities already existing and to provide guidance and training for those which need strengthening." 1/

The three primary methods being used by IHS to achieve Indian involvement are:

1. Indian Health Board participation in policy-making. 2/

2. Tribal operation of health programs (by contracting with IHS for IHS programs, and by obtaining grants from other federal agencies for other health programs). 3/

1/ IHS OPS, Objective for FY 1972, PHS.

2/ Indian Health Boards are being developed at all levels--Service Unit, Area, Headquarters. Their purpose is to provide a means for Indian input into policy-making and, ultimately, to have all program decisions made jointly by IHS and tribal boards (IHS, OPS Plan FY 1972). This appraoch will include identifying the critical factors and logical steps of Health Board development to assist IHS in helping tribes establish systematic approaches to accomplishing their goals (IHS OPS Plan FY 1974).

3/ Activities are being emphasized that provide Indians with mechanisms to assume not only a policy role, but also an operational role in the provision of health services (IHS OPS Plan FY 1972). IHS will continue to work on mechanisms whereby Indian tribal groups will receive funding to manage or direct their own programs. Contracting with qualified tribal groups will continue. Technical assistance will be provided those tribes desiring it, to help them develop the capability for receiving direct funding. Tribal groups are increasingly urged to apply to other federal agencies for assistance on their own for support programs such as TB, MCH, Nutrition, Family Planning, and others. IHS will provide expertise and experience in assisting the tribes in these activities and will provide a coordinating role where possible (IHS OPS, Plan FY 1972, see also OPS FY 73 p. 1).

3. Increasing the number of Indians at decision-making levels in IHS. 1/

IHS policy is that it will make these methods available and assist tribes in implementing them; the principles of self-determination demand, however, that each tribe have the freedom to decide on its own how much involvement it wishes to have with IHS and its health programs and how fast it wishes to move in increasing that involvement. Therefore, IHS will respond to tribal requests for assistance, but will not force anything on a tribe. This is the IHS stated policy on Indian involvement. The success of its implementation by IHS and by the various Indian tribes has varied.

1/ Within the IHS organization, emphasis on increasing Indian qualification for employment and promotion will continue. As responsible positions become available, Indians will be given every opportunity to assume them. (OPS Objective FY 1972).

II. B. RESPONSIBILITY FOR INDIAN INVOLVEMENT IN IHS

IHS has established "increased Indian involvement in health programs" as one of its major program objectives. The IHS position is that its entire staff, 7,000 strong, is working to achieve this objective. But if an objective is to be accomplished within a system, specific assignment of responsibilities must be made. IHS has assigned to various divisions, branches, and offices the responsibility for carrying out the necessary tasks to achieve increased Indian self-determination.

1. Headquarters

a. Division of Indian Community Development (CD)

In Headquarters, the Division of Indian Community Development (CD), directed by an Indian, heads the IHS program for Indian participation. The IHS Manual describes the responsibilities of the Division as follows:

1. Participates in Service-wide executive policy formulation and execution.
2. Identifies the need for and characteristics of optional means and modalities for Indian program participation.
3. Implements new methods and techniques for Indian community participation in and management of their health programs.
4. Coordinates provision of technical assistance training and consultation to tribes and other Indian communities desiring to implement local control options.
5. Advises on the Indian community development implications of the Service's plans, programs, and operations.
6. Provides direction and coordination for day-to-day operation of Special Programs.

However, the Divison is only about three years old, has a staff of only three, and has not yet assumed responsibility for all functions listed for it in the Manual, although it is expected to grow in size and scope.

Ranking as one of the four Division directors in Headquarters, the director of CD serves in an advisory capacity to the Director of IHS on all policies relating to Indian involvement and serves as an ambassador to Indian people to promote Indian involvement in IHS programs. The primary role of the Division at this time is providing technical assistance and financial resources to special Indian community development projects, including those not traditionally recognized as being within the service jurisdiction of IHS, such as urban Indian programs and terminated Indian tribes; e.g. the Minneapolis Indian Health Board, Seattle Indian Health Board, and California Rural Indian Health Board.

The CD Division does not have a line item budget or staff at the Area and SU levels to support its community development activities. However, during the last few years, Congress has allocated separate money for a special fund for community development projects: in FY '74, $625,000 and in FY '75, $1,125,000. This money is used to fund tribes and Indian organizations to develop their management and technical capabilities and to staff and manage their health programs.

The CD Division publicizes the availability of these funds, receives and screens proposals, and makes recommendations on funding of the proposals, although final sign-off authority lies with the IHS Director. This past year, grants were made to such groups as the Papago Executive Health Staff for training and travel money, to the Hopi Tribe for the establishment of a tribal health department, to the Sioux Health Board for training, to the Minneapolis Indian Health Board for the development of an urban Indian health program and to the United Southeastern Tribes for planning and training. The Division received over two hundred proposals, many of which were viable, but had funds for only a limited number.

The CD Division has tended to function as a "loner," working directly with Indian groups at the local level, rather than through or with the Area Offices and Service Units. The Division has not taken the lead in coordinating, motivating, and providing technical assistance to the AO's and SU's on community involvement. It has stayed off by itself, almost as a separate agency within IHS. As a result, IHS staff interviewed indicated a great deal of antagonism between the CD Division and the AO's and SU's. The CD Division's perception of the AO's bureaucrats is that they do not understand community development. Some of the AO staff do not want to be identified with the CD Division or its projects

because they consider the Division a "loser." Although its projects have been interesting, its impact has been limited and it has not played the significant role it might have in the AO's approach to community development. Rather, the antagonism between the Division and the field staff has tended to complicate the already complex job faced by tribes and IHS in promoting Indian development.

b. Office of Tribal Affairs (OTA)

The other office at IHS Headquarters that deals directly with Indians is the Office of Tribal Affairs (OTA). According to the IHS manual, 1/ the OTA has four objectives:

- To prevent or reduce problems of ongoing program operations stemming from relationships between the Division of Indian Health and components of the total Indian field.
- To contribute to effective program development and implementation, and long-range planning functions of the Division.
- To strengthen mutual understanding and develop positive and organized support for Division of Indian Health policies and programs by Indian and related interested groups.
- To develop the broadest possible sensitivity and empathy of Division staff to the total Indian field; its impact on operations; and the ways by which individuals can effectively deal with its components.

While the CD and OTA roles seem to overlap, there are discernable differences in their activities. One method of describing the OTA is to think of it as a small Bureau of Indian Affairs (BIA) office within the IHS system, dealing with overall tribal matters; the impact of decisions on the legal rights of tribes; and internal IHS relations with other offices in their development of programs with tribal groups and organizations. Within the IHS system, the Office of Tribal Affairs has no clearly defined role in advocacy or community development, since that is presumably being generated by the Division of Indian Community Development. It does, however, have OTA counterparts at the AO level, with whom it works to accomplish its objectives. Because the Office of Tribal Affairs maintains continuing working relationships with tribes, because it does have counterparts at the Area level, and because it is much more integrated into IHS and tribal bureaucracies, it is more visible to tribes and IHS staff throughout the country. However, the role of coordinating community development throughout the IHS structure is clearly not its function or responsibility.

1/ Indian Health Manual, TN 48 (9/29/64).

The Director of IHS and his staff have perhaps borne the greatest burden of the load at Headquarters--of carrying the message of Indian involvement by inspiring, urging, and pressuring the AO's and SU's into action. However, the Office of the Director is not properly equipped to provide on-going coordination or technical support to the field. Therefore, despite the existence of the CD Division and the Office of Tribal Affairs, there is no office in Headquarters to which Indian groups can identify as having the responsibility for overseeing coordination, and for providing support services to the IHS staff in the field on Indian involvement.

2. Area Offices and Indian Involvement

The Area Offices have a number of functions in regard to Indian involvement. They work with the Area Indian Health Board, oversee IHS's obligation for the CHR program, assist the SU's in carrying out their responsibilities, and work directly with tribes on special projects. The structure for doing this varies from AO to AO. In most, it rests in the Office of Tribal Affairs. Other AO's have created new offices by combining the OTA with other community-oriented positions. For example, the Phoenix Area has established an Office of Indian Community Development. In all the offices visited, a major problem seemed to be the lack of sufficient staff to devote the extensive time needed to carry out IHS's responsibilities for community development. In one AO, a single staff person was responsible for the Area Indian Health Board, and was a liaison with the tribes on Indian involvement; obviously he would perform none of these functions thoroughly.

The one function that seems to suffer most is the provision of leadership and technical assistance by the AO to the SU's, an essential element if the SU is to meet its responsibilities to the tribes and Health Boards. Yet there was little evidence that this was either happening or likely to happen. To do so would require AO staff to spend a significant amount of their time in the field. The Phoenix AO dealt with this problem by stationing an AO staff person at an SU, with responsibility for two other SU's in the vicinity who assisted the three SU's and tribes with human and community development programs. The Phoenix AO had also established a Tribal Projects Review Board, consisting of staff from the different branches of the AO. The idea was that when IHS staff went out in the field to work with the SU, they would also spend some time working with the tribal health programs and tribal leaders to help the tribe get an overview of its various health projects, what they could be doing, and how they could be relating the programs to each other. It seems like a potentially useful idea, but the head of the review board was sent elsewhere on temporary assignment, so the idea has not gotten off the ground.

Area staff indicated that when IHS initially assumed responsibility for Indian involvement and community development objectives, it was not given additional positions or resources with which to carry them out. As a result, it has had to stretch its existing resources further. However, an over-extended staff and a haphazard approach means there will be too many commitments that cannot be kept and follow-up that cannot be done; both outcomes are damaging to a process such as community development, which depends to a large degree on mutual trust and mutual solution of problems.

The branches of Mental Health, Social Services, and Health Education are also doing some work in the area of community development with tribes and with other Indian groups. Some staff felt that there was a sense of competition among these branches and OTA over responsibility for community development, which needs to be settled so that an organized approach can be developed. However, in most of the AO's visited, the leadership for Indian involvement came from the Area Director (AD). He seemed to be the one most thoroughly imbued with the IHS philosophy, and with the stature to motivate his staff and shape up recalcitrant personnel. Tribal leaders correctly perceived the AD as the center of power in the Area, and looked to him when they needed support or resources for increased involvement. Due to his many other responsibilities, however, the AD could not be sufficiently accessible to tribes or staffs, and therefore, was unable to provide the continuity of leadership and support that the Indian involvement program needed.

3. Service Unit Level

The Service Unit Director (SUD) has primary responsibility for carrying out IHS's Indian involvement program at the SU level. At some of the SU's visited, the SUD's made it clear that they "did not give a damn" about Indian involvement and tended to view Indian involvement as a "monkey on their back" that just further interfered with their already formidable problem of running an adequate medical program under crisis conditions. The SUD's went through only the most perfunctory motions in carrying out their Indian involvement responsibilities, with little negative feedback from the AO. In most of the SU's, however, the SUD, the health educator, or some other member of the staff was interested and was trying, despite the crisis atmosphere that dominates the SU.

Because the SU staff received almost no support or technical assistance from the AO or any other place, tribal leaders had to deal with novice community organizers who were making the

same mistakes that hundreds of others had already made the first time they attempted to be a resource for community organization. While IHS has assumed the responsibility for "helping tribes establish systematic approaches to accomplish their goals," it has not given its staff at the local level the training, back-up, or other support necessary to carry out this responsibility.

There has been some discussion in IHS of training the SU health educators and social service personnel as community developers. Dr. Johnson indicated that a pilot training program was being prepared for this purpose. If this approach is followed, it could significantly improve the way in which IHS is handling its community development program at the SU's. While, as Dr. Johnson pointed out, not every health educator is a community organizer, this approach will establish a trained staff, preferably of Indians, with specific responsibility for working with the tribes and Boards.

The Office of Research and Development (ORD) has provided in-depth development support to several tribes and Health Boards, such as the Papago Executive Health Staff and the Alaska Native Health Board. Both groups are now impressive organizations in the vanguard of Indian involvement in health programs. In both cases, ORD committed substantial resources. Since the ORD staff does not have direct health service responsibilities, it is removed from the day-to-day pressures under which AO's and SU's operate, and its staff is able to devote uninterrupted and concentrated time to these projects. However, ORD does not have enough staff or resources to support these activities in more than a few places at a time throughout the country. Also, the role of ORD should be to develop successful models that are "exportable," rather than assuming the responsibility of continually duplicating such models themselves.

4. Guidelines

Pursuant to its policy of delegating implementation to the AO's, IHS Headquarters has not promulgated guidelines on Indian involvement. Several of the AO's have issued general Indian involvement guidelines. The IHS position seems to be that Indian involvement is an Indian process and basically an Indian responsibility. Theoretically, this position is within the philosophy of self-determination; practically, it creates chaos and paralysis. Guidelines setting out IHS responsibilities and commitments on Indian involvement and assigning specific staff responsibility do not impinge on the freedom of tribes; rather they solidify the IHS commitment to the program within the bureaucracy and make IHS accountability possible.

A comment heard throughout the interviews was that the IHS Indian involvement program is all in the head of the IHS Director and could disappear as soon as he steps down. While these comments were usually made by staff as a rationalization for their opposition to Indian involvement, the lack of concrete guidelines gives them an excuse for not supporting the effort. It also fails to provide staff committed to Indian involvement with support necessary for their efforts.

It also denies Indian groups the ability to determine who in IHS is responsible for responding to them and assisting them to operationalize their ideas. If the AO's and SU's are going to be accountable for their performance on Indian involvement, such accountability will be achieved by the Indians themselves. But as the various consumer movements have shown, consumers are powerless against officials whose only mandate is to do what is in the "best interest" of the people they are serving. They need specific written regulations which have the force and power of law and guidelines which tell them what they are entitled to expect from the officials, and which give them a handle for asserting their rights when the "best interest" concept gets abused.

OEO and HUD-Model Cities developed community development guidelines. By themselves guidelines do not make community development happen; but they are a necessary tool to make a bureaucratic system accountable and responsive.

5. Funding

There is no separate line item in the IHS budget for community development available to the AO's and SU's. The $625,000 community development fund is for a limited number of special projects. Money to pay for such costs as travel for Health Board meetings or outside technical assistance must be pulled from other AO and SU programs and offices, which are already underfunded. This places severe restrictions on the ability of IHS staff to respond to the requests for support made by Indian groups. In one Area they could only call AIHB meetings four times a year because it costs about $2,500 a meeting, and the Area could only allocate $10,000 a year for AIHB purposes. In addition to limiting the funds available to support Indian involvement, the fact that funds have to be allocated from ongoing programs inevitably creates a conflict situation: IHS versus the Health Boards; health services to Indians versus Indian control.

In the past, there have been other funding sources that could have been used for these purposes. OEO funding has been severely limited, however, and has not played a major role in planning for health. General revenue sharing funds are too small for most

tribes and there are enormous prior claims on those limited resources. 314(b) funds (comprehensive health planning for local government, specifically for planning for the utilization of federal health monies in conjunction with local health services) would presumably be the most reasonable to pursue, but Indian tribes have not been designated local planning areas, although minor changes in this legislation could permit large tribes or groups of small tribes to qualify.

II. C. INDIAN HEALTH BOARDS

Over the past few years, Indian Health Boards have developed at the Service Unit, Area, and national levels. Their progress has been uneven and erratic. The Service Unit Boards, composed of tribal members elected or selected by the tribe, are agencies of the tribal government. The Area Boards are composed of representatives of each of the SU's in the Area; however, Area Board members are usually chosen by the tribal chairman or council rather than by the SU Health Boards. Most Area Boards are arms of IHS, although some are incorporating and thereby establishing an independent status. The National Indian Health Board (NIHB) consists of representatives of the Area Boards, selected by these Boards. The NIHB, which has a full-time staff and office located in Denver, is in the process of obtaining corporate status.

IHS views the Boards as a primary source of Indian input into IHS policy-making and envisions that ultimately IHS policy will be made jointly by the Boards and IHS. Following its decentralization philosophy, IHS Headquarters did not mandate the creation of Health Boards, but left this up to each Area to move at whatever pace it felt was most advisable. As a result, some Area Boards have been in existence for several years and have had increasing impact, while others are just starting out. At the SU level, the same is true; also, at some SU's, Boards do not exist at all or were started, but subsequently collapsed, and some tribes have decided to stay with their existing health or HEW committee, rather than switch over to the Health Board structure.

At the reservations visited for this study, the impact of the Health Boards was noticeable and constructive where there was strong tribal health program and presence. The SU's on those reservations appeared to be much more responsive to Indian health priorities, and the SU staff had a greater sense of working for the Indian people, rather than for the IHS bureaucracy. There was clear progress towards the development of two equal components of the health system on the reservation, one tribal and the other IHS, with mutual respect and impact on each other. These few examples were living proof that a strong tribal health presence could make a significant difference in the quality of health services received by Indians.

However, on those reservations the impact did not come from the Health Boards alone, but almost always from the Boards working in conjunction with full-time professional tribal health staffs or multi-tribal health staff (e.g. USET). Sometimes it was achieved without a Health Board at all (e.g. Choctaw). In contrast, the typical SU Health Board was composed of tribal members without health backgrounds, serving on the Board in addition to holding down full-time jobs or fulfilling other

obligations, and without a tribal health staff to whom they could look for support. For the great majority of the members of the typical Boards interviewed, their perspective on Health Boards was one of bewilderment. Having taken on the job and desiring to help their people, they were trying to make sense of the Health Board concept and find the resources to help them do a creditable job. They were concerned about a lack of definition to their roles, lack of authority, and lack of time, staff, and training to enable them to carry out their functions.

1. Problems Identified by Indians and IHS Staff

a. Role of Boards

At this point, the persons interviewed were unclear as to what a Health Board could realistically do to help improve health services to Indians. The IHS message to the Boards is that they can do anything they want, within the limitations imposed by IHS's legal and fiscal responsibilities. A Board can define its own role in light of its own particular tribal needs and directions. But rather than seeing unlimited potential open before them, most of the Board members spoke more of the obstacles and problems confronting their efforts to develop a meaningful role. They mentioned the lack of knowledge of the options open to them; the vagueness of their authority; the lack of training, time, staff, and funds; and the almost insurmountable difficulties experienced by an untrained lay person confronting an IHS health professional in accomplishing anything at all. Members were aware that often their priorities were ignored or given only pro forma consideration. Their frustration often outweighed their sense of dedication and, at times, they withdrew from serious participation in what appeared to them a charade.

Dr. Johnson believes that IHS should not dictate to a Health Board what it should do. If a Board is to develop an autonomous status and not just be a rubber stamp of IHS, it must work out its own role and method of operating, one that is in line with its tribal perspectives and needs. The potential for such an approach is evidenced by the Papago Executive Health Staff. Starting with a blank slate, they created their own model and role. It is a uniquely Papago model that incorporates the traditional Papago style of operation. 1/ As a result, the group is much more effective than it might have been had IHS imposed on them a standard shape and role structure. However, this was not a typical Health Board situation. The members of the Executive Health Staff are all full-time Papago health professionals

1/ See Section entitled Three Tribal Models.

(CHR coordinator, alcoholism coordinator, etc.), who received a substantial amount of technical assistance from HPSC and others and had funding for this purpose. Members of the Board met once a week for over a year to develop their structure and role. Their impressive achievement confirms Dr. Johnson's approach. But it was not done in the near-vacuum to which most other Boards are relegated.

b. Authority

Board members also expressed concern about the nature of their authority; did they actually have authority and power to influence IHS policy of were they simply a tool that IHS used for its own purpose? The words from IHS were hopeful, but the reality they experienced was rarely congruent with the words.

Formally, the Boards are advisory; no law passed by Congress gives them authority within the IHS structure. It is questionable whether IHS could legally delegate to a Board specific authority that Congress has vested in IHS. IHS cannot issue a guideline or regulation saying that the Board shall select the SUD; it can only say that the Board shall advise IHS on selection of a SUD and that IHS shall listen. But IHS still has to make the final decision. If the AD does listen but then takes action in opposition to the Board's recommendation, he has not violated the letter of any IHS regulation. This is because the only official legal authority a Board has is to advise. Presumably Congress itself would have to grant program authority to the Boards.

That the Boards do not have independent legal authority does not mean they are rubber stamps. It does mean that the actual authority they do have becomes a very personal, existential thing, depending almost completely on how much respect and weight the SUD, AD, or IHS Director accords to that Board's decision. If a Director is willing to implement the Board's decision, even when it conflicts with his own, then the Boards have power, even though power can be withdrawn at the will of IHS. But if, instead, IHS listens to the Board and then goes ahead and does what it wants, then the Board has no power under any circumstances. Every act IHS takes in regard to the Boards determines how much power the Boards have.

Therefore, the answer to the question many Board members were asking, "How much power does a Board really have?" depends primarily on how much power IHS is voluntarily willing to relinquish to the Boards. But this places the SUD or AD in a

difficult position. While his primary responsibility is to make an overworked Service Unit or Area Office perform its health delivery mission, he is also expected to assist and encourage a lay Indian Health Board to help make those decisions, possibly in disagreement with his own perception of what is best or necessary. This is not to say that the SUD's or AD's view should prevail, but as experience with other health programs has shown, it is expecting a great deal from a Director to be completely open with the Board and to voluntarily yield to a Board's conflicting advisory decision. Board members cited many cases where the SUD either ignored their views, or formally agreed to them and then went ahead and did as he thought best. The same is true at the Area level. According to one Area Health Board member, "the Board is only treated as though it had any policy-making function when it suits the AD's convenience--mainly in situations where the AD, for political reasons, doesn't want to make a decision for himself. At those times he will say that that is for the Board, not him to decide."

While the Boards do not have the authority to make a SUD or AD comply with their requests, the IHS official one level above--the AD for the SUD and the IHS Director for the AD--does have that authority. Since he is a level removed from day-to-day pressures of the SU or AO he is also free of some of the conflicts. Therefore, much of the responsibility for legitimatizing the Boards' authority rests with the AD or IHS Director. Several Area Boards commented on the strong, positive psychological impact on both the Board and the AD that occurred when the IHS Director "reached down from on high" and ordered the AD to carry out the Board's recommendations. The same positive boost for SU Boards would likely follow situations in which the AD overruled a decision by a SUD which conflicted with the SU Board's position.

Since an appeal to a higher level is basic to the legitimacy of the Boards at this time, it becomes very important that the AO or Headquarters be easily accessible to the Boards and be willing to support them. Yet IHS does not have adequate lines of authority and communication from the Boards to the AO or Headquarters. Board members said that their usual approach was to try to contact the AD or IHS Director directly, but found them so busy that they were usually inaccessible. Many of the IHS Area staff that are in regular contact with the Boards and hear their complaints indicated that they also had trouble gaining access to the AD's. Boards should press IHS to establish clear procedures for appeals or complaints by the Boards to the next highest level. IHS should designate a staff person in the AO's and Headquarters as the primary contact with the Boards at the next lowest level. That person should have direct access to the AD or IHS Director, and a time limit for responding to requests made by the Boards

should be established. While intervention from above is not the most ideal method of administration,it appears to be necessary until the Boards and SU's (or AO's) establish their own working relationship.

Boards and the SUD or AD should also try to put their mutual arrangements into writing. While not legally binding, this could help remove some of the fuzziness from the present relationships. Guidelines or statements of agreements could be drawn up by the Boards specifying the mutual roles and responsibilities of the Boards and the SUD, and the method of appeal to the next highest level. Such documents should be viewed as flexible, subject to change and delineating only the minimum role of the Board. The process of negotiating the agreements is almost as important as what is actually put down on paper. If the agreements are reached through an arms-length negotiation between equals, it will commit both parties more strongly to the writing and will create an understanding that goes deeper than the paper. However, in most cases unless the Boards have a staff or other trained health person to represent them in the negotiations, the documents may reflect the SUD's thinking rather than the Board's.

c. Training

Legal authority is not the only means by which a Board could have a significant impact on its SU. A trained and knowledgeable Board that is confident in its ability to deal with health issues and able to talk with the SUD as an equal can have substantial actual power, whatever its legal status. For this reason the Board members were concerned about the lack of training available to them. Most had no health training or prior knowledge of how the IHS management system operates, and yet were being asked to make decisions requiring knowledge of both.

Little formal training has been provided to the SU Boards. The Desert Willow Training Center said that it was available to train local Boards, but it had only received requests to work with three of them. In general, Board training has been provided by the SUD, his staff, or the Area staff for an hour or so once a month when the Boards have their meetings. No outside technical assistance has been made available to the Boards, nor have the AIHB's or NIHB been used as a training resource. The Area Indian Health Boards and National Indian Health Board have the potential to become such a training resource, but they have not been given the staff, funds, or training to equip them to perform this role. Contracting training funds to the NIHB and AIHB's would provide them with the resources.

d. Need for Staff

Indian Board members felt it was unrealistic of IHS to expect them to do background research and develop health positions for input into the IHS program during the few hours a month they had to devote to IHS. Without a staff working full-time on the issues, they felt they would never be able to prepare well-reasoned positions that would permit them to stand up to the doctors, the SUD's and the other health professionals who opposed them. Also, they complained that the SUD often did not accept the fact that this was a part-time community activity for them. The SUD would get angry if Board members did not show up when he called a meeting, taking this as proof that Indians were not interested in IHS. For this reason, they felt that each Board needed a full-time staff person, possibly using the money now allocated for the SU Health Educator.

One way to overcome the problems of both staffing and training is for a tribe to appoint tribal members who are health professionals to its Health Board. They would be familiar with health systems and health concepts and could provide technical leadership to the Board. If the Board member was also a tribal health employee, such as a CHR coordinator, he could be assigned, as part of his tribal job, to do staff work for the Health Board. The Papagos have taken this concept to its furthest point. The Papago Executive Health Staff, which is composed of the heads of the tribal health programs, and is similar to a tribal health department, also sits as the tribal Health Board. Therefore, the entire Board is made up of tribal health professionals. They have found this appraoch to work successfully but cautioned about possible dangers also inherent in it. (The Papago approach is discussed in detail in the Section entitled Three Tribal Models.)

e. Funding

The Board members also felt handicapped by the lack of an independent budget for the Health Boards. Presently, any money available to them must be painfully squeezed out of the existing SU budget. In many places there were no funds to pay the Board members' mileage costs, and in almost all SU's there was no money to enable the Board to attend conferences or to bring in outside technical assistance. Such resources are necessary to enable them to gain alternative perspectives and establish positions independent of the SUD. Where such funds have been made available, they have been used very productively. The

Papago Executive Health Staff has received a grant from the IHS Community Development fund to be used for this purpose. It has given them the wherewithal to strengthen their skills and their sense of independence from IHS. IHS should fund, or assist Boards to obtain independent funding, so they can make similar steps to build their capability, and thus their independence.

2. Possible Functions of Boards

IHS's statement that Boards can do anything they want is neither realistic nor possible within the existing framework. On the other hand, IHS staff, particularly Indian employees, identified a broad range of roles that Boards could productively play once some of their problems were eliminated. They also felt that there were a number of important services the Boards could render that did not require an extensive knowledge of health, but rather, utilization of their knowledge about Indian approaches and attitudes:

a. Dignity

The Boards could advocate dignity for the Indian consumer in the IHS system. Doctors and other health professionals concentrate on what they can do best, which is delivering medical services. In doing so, particularly under crisis conditions, they tend to lose track of the fact that their patients are human beings who want and deserve to be treated with dignity. (Application of this concept to particular problem areas is discussed in the sections on Cultural Sensitivity and on Outpatient Clinics. Boards could help insure that health services are delivered in a manner which insures the dignity of the consumer.)

b. Cultural Sensitivity

Many Health Boards have been told that their role is to interpret IHS to the Indians. There is at least an equal role, however, in explaining Indians to IHS, thus helping to make the IHS delivery system culturally sensitive to Indian values and perspectives. Many IHS staff expressed the view that delivering services to Indians was no different from delivering services to any other poverty group. Others felt that the time pressures compromise IHS's ability to deal with the trans-cultural setting.

On the other hand, the Indians interviewed indicated how strongly the people have retained their Indian viewpoint towards health care and how this complicated their ability to receive services from IHS. By bringing this input to the IHS system, the Health Boards are in a position to make it more Indian-oriented. In this area, because the Boards have superior knowledge, they are not at the same disadvantage as when arguing medical issues with IHS staff. (For a full discussion of this issue, see Section on Cultural Sensitivity.)

c. Employment

EEO officers in particular emphasized the need for Indian Health Boards to take the lead in pushing for greater employment of Indians in policy positions within the IHS system. With non-Indians dominating the personnel offices and executive officer positions, the EEO people feared that the leadership on this issue would never come from within the IHS personnel system. Boards that have taken up on this issue have too often been put down by IHS staff, who cite regulation after regulation as reasons why the Board's Indian choice could not be hired. On the other hand, Indian groups that took up on the same issue with the BIA discovered that the regulations permit just about anything a knowledgeable manipulator of the personnel system wants to accomplish. This means the Boards will have to get training on personnel matters or develop an alliance with the Area EEO officer, so they will be able to deal with personnel issues on an equal footing with IHS staff.

d. Monitoring the IHS Contract Care Program

Many Indian consumers have complained about the discriminatory and insulting treatment they have received at contract care facilities. Also Indian health workers have rights to employment in those facilities which have never been actively enforced. Health Boards could fill the gap that presently exists in these areas by monitoring the treatment of Indians and the employment practices at contract care facilities and channeling complaints to IHS, the Office for Civil Rights, and other civil rights agencies. (See the Section on Contract Care for further discussion of this role.)

e. Setting Priorities

IHS staff most often defined the Board's role as that of setting priorities, but several problems relating to this function have already been identified:

(1) Some Board members felt that IHS used this to impose on the Boards the hard decisions that IHS did not want to make. For example, should contract care money be spent on ten otitis media operations or one kidney transplant.

(2) Since most of the IHS money is tied up in fixed programs there is little money available to implement the priorities set by the Boards, which makes them look ineffectual to their communities.

(3) Listing priorities in numerical order without considering such factors as relative impact among viable alternatives, or trade-offs between new programs and old programs, made the process unrealistic and built up false hopes.

(4) Board priorities such as alcoholism or outpatient clinic overcrowding were dismissed by IHS staff, who claimed that there was nothing that could be done about them. Without independent information with which to challenge these statements, the Board member when informed about model programs developed by ORD, indicated that they would like to propose them to their SUD. A Board needs a source of information, written in layman's language, on the innovative programs that have been tried successfully elsewhere and that offer options to what is presently being done at its SU. Since ORD develops many of these new concepts, and is aware of other exemplary programs, it might assume the responsibility of issuing regular publications for Health Board members, written simply and laying out innovative alternatives to the existing system.

f. Evaluation

Several SU Health Boards (as well as many Area Boards) have obtained contracts from IHS to evaluate part of the IHS program from a consumer perspective. In addition to providing a formal means of commenting on the impact of the IHS system, this role gives the Health Boards funds to hire a staff and a chance to get some in-depth knowledge of at least part of IHS's operations.

For example, the Oklahoma Area Health Board chose to evaluate the IHS Area Office. The contract enabled them to hire a full-time staff person for the evaluation who was also in a position to do other work for the Board, and to pay the Board Members on a part-time basis to do parts of the evaluation, which meant spending time in the Area Office and learning more of its inner workings.

g. Handling Individual Consumer Complaints

Many Board members and IHS staff felt their Board's only useful function was conveying complaints from consumers to IHS administrators. Both Board members and IHS found this to be very frustrating. Few results were accomplished, and it consumed a lot of time that both parties thought could be better spent on other subjects. On the other hand, consumers legitimately saw the Boards as their representative to IHS and as the only Indian vehicle for relaying their complaints. The problem seemed to be that there was no procedure for handling complaints.

Board members would bring up complaints and the IHS staff would promise to look into them. At some later time IHS would report back, usually defending what IHS had done, and then the Board member would have to relay this back to the consumer--an unenviable task. Without a formal procedure and clearly defined roles, this resulted in increased tension between IHS staff and the Boards.

In contrast to IHS, programs such as Medicare and Medicaid, and HMO's, have formal complaint procedures with deadlines and specific roles for all parties, including the Board members and the consumers. Handling consumer complaints is a legitimate Board function in many health programs. But if IHS Health Boards are going to assume this role, they should be assisted in developing a formal complaint system that gives some structure and order to the procedures, adapting from those used in other health programs.

Conclusions

These are some of the many roles Health Boards could play if they had proper support. Each Board should receive some assistance in working out its own appropriate place in the Indian health world. In discussing this issue, Dr. Johnson and other

staff indicated that there are problems with IHS taking responsibility for helping Indians work out their roles. As a bureaucracy in the federal system, IHS has its own interests and agenda which are not always identical to those of the Indians it serves. It was questioned whether an IHS employee would be able to lay out honestly the possible roles open to the Board or whether he would hold back, consciously or unconsciously, those which were not in the best interest of IHS. Therefore, an outside group, such as the National Indian Health Board or other Indian group interested in health should be contracted to assist the local Boards.

Like many other recommendations, this requires funds. The money presently committed to Indian involvement programs is not a substantial amount (the $625,000 fund, plus the amount spent through the evaluation process). IHS has sought greater funding for its community development program, but has not received it. Money more than words is a good indication of commitment to a cause, and IHS has had very little money to support its expressed good intentions.

II. D. CONTRACTING WITH TRIBES AND HEALTH BOARDS

Contracting [1] is a second method being used by tribes and IHS to increase Indian involvement in health programs. Under contracting, program responsibility for health programs is transferred from IHS to the tribe. Through a formal contracting procedure the tribe agrees to provide particular services and IHS agrees to pay the tribe to perform those services. This process gives the tribe the formal authority that is not legally available to the Advisory Health Boards. The tribe is now running the program and it has the responsibility and authority to set priorities, hire staff, and make all other program decisions. Under the principle of self-determination, each tribe decides which programs, if any, it wishes to contract from IHS.

There has been a tendency, more so in the BIA than in IHS, to equate "contracting" with the larger process of "self-determination." The perspective on contracting taken here is a much more limited one, with contracting being only one aspect of self-determination; our position is more in line with the comment of one Indian leader testifying on the Jackson Self-Determination Bill (S.1017):

> "We feel that the Bill should reflect an awareness of the distinction between contracting as one vehicle for self-determination as opposed to being an end in itself and/or synonymous with 'self-determination.' If 'self-determination' is to mean no more than contracting, then very probably those who fear the new policy as 'termination' in disguise have much to fear, and those of us who do not share that fear are naive in the extreme. Rather, the definition of self-determination should focus as much on the process through which a Tribe will determine its own destiny as much as on 'concrete' goals." [2]

1/ Contracting, as discussed in this Section, is contracting between IHS and Indian tribes or groups for the transfer of operational responsibility for health programs presently run by IHS to the tribes or groups; as distinguished from Contract Health Services (CHS) or contract care, the process by which IHS contracts with private medical providers, almost always non-Indian, to provide care that IHS cannot provide itself because it lacks either facilities or staff.

2/ Testimony of Peter MacDonald, Chairman, Navajo Nation, before the Senate Subcommittee on Indians in regard to the Jackson Bill S. 1017.

1. Types of Contracts

From the perspective of Indian involvement, there are two types of contracts. First are contracts for services which have very little to do with policy-making or shaping the kinds of health services that Indians receive. These include such services as laundry service, garbage disposal or construction of sanitation facilities. Other than giving tribes some experience in administering federal contracts, these contracts do little to promote Indian involvement in health care. Their primary role, it appears, is to provide employment to Indian workers and profit to private Indian firms (an extremely important function, but not directly connected with the concept of Indian involvement in health).

The second type of contract is one where tribes make policy and deliver health services that directly impact the quality and quantity of health services Indians receive. It is the second type of contract that this section discusses. Services that IHS had previously provided may be contracted: a tribe contracts to run a hospital that had been run by IHS; 1/ or a tribe may contract with IHS to perform new health services, such as in the Community Health Representative (CHR) program, which was contracted to the tribes from its inception. By operating such programs, the tribe, at least theoretically, has the authority and opportunity to set its own policy and thereby remake the delivery of those services in an Indian image.

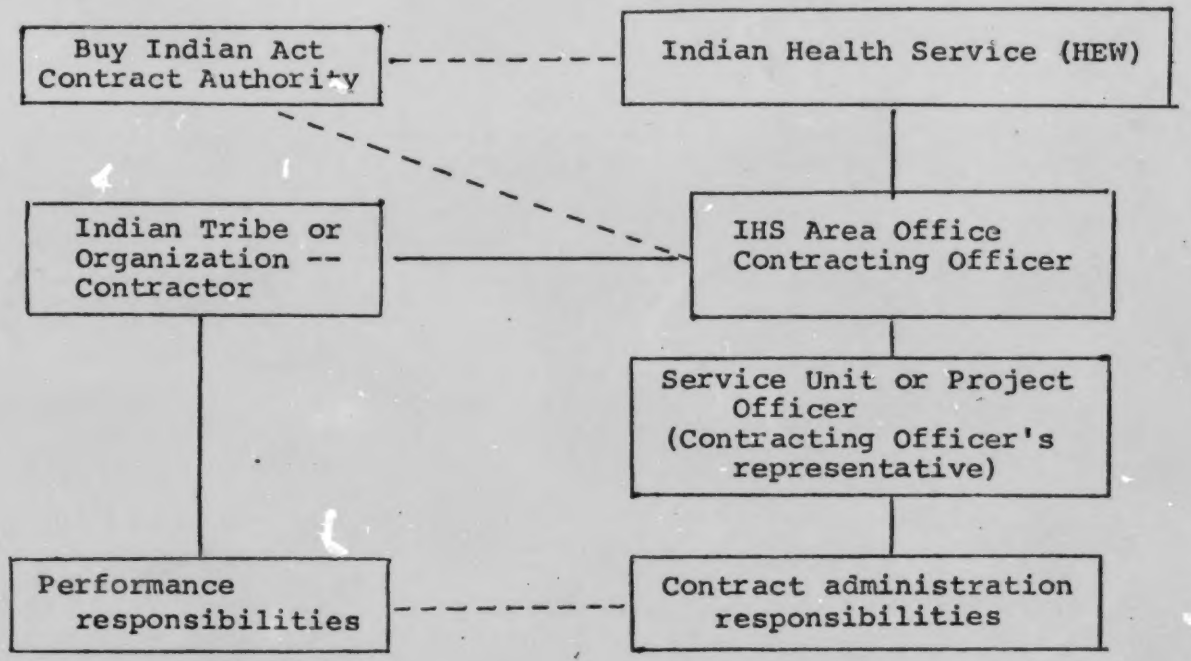
2. The Contracting Process

The contracting process is a technical one, the same procurement process used by the federal government to purchase any goods or services from a non-federal agency. In this case, the Indian tribe is the Contractor and IHS is the Contracting Officer. The degree of Indian involvement and participation is determined by the terms of the contract. Unless there are special provisions, the contractor assumes the same responsibilities and liabilities as does any other federal contractor.

The CHR program offers a good example of the contracting process. The IHS contracting officer is usually the Contract Office Branch Chief in the Area Office. In most, if not all cases, the CHR program is contractually responsible to the SUD who is normally designated the Project Officer--the local SU

1/ e.g. Choctaw Tribe in Mississippi is preparing to contract their IHS hospital once a new one is constructed.

representative of the AO Contracting Officer. The contractual relationships and lines of responsibility may be expressed by the following schematic diagram:


Buy Indian Act Contract Authority
Indian Health Service (HEW)
Indian Tribe or Organization -- Contractor
IHS Area Office Contracting Officer
Service Unit or Project Officer (Contracting Officer's representative)
Performance responsibilities
Contract administration responsibilities

Technical provisions and clauses in the general provisions of the contract contain nothing that is likely to further Indian self-determination. Provisions describing the scope of the work to be furnished by the Contractor (Indian tribe) merely specify what the Contractor is required to do, with no provision related to the fostering of Indian self-determination. Because of this, some Indians interviewed expressed doubt that contracting with Indian tribes is likely to foster Indian self-determination. They view the emphasis on contracting as fostering only the growth of purely technical contractual relationships between the IHS and the tribes.

Therefore, if contracting is to be a viable vehicle for Indian involvement (and self-determination), it must be something more than just a technical process of transferring certain legal responsibilities and liabilities from IHS to the tribes. Otherwise, "Indian tribes might well find themselves merely contracting the frustration of Public Health Service Administrators." 1/

1/ Indian Self-Determination and Education Program, Hearings before the Subcommittee on Indian Affairs of the Committee on Interior and Insular Affairs, United States Senate, 93rd Congress, First Session, on S. 1017 and Related Bills, Statement of Lucy Convington, First Vice-President, Northwest Affiliated Tribes, p. 201.

Unfortunately, the primary vehicle for contracting, the Buy Indian Act 1/ provides for no more than a purely contractual arrangement between a tribe and the IHS or BIA. According to a study done for the Gila River Tribe:

> "This contract system is not one which was developed specifically to achieve the goal of transfer--its successes and failures along this line have been haphazard. For instance, the contract approach does not include any program of long-range training in management and administration. It focuses entirely upon the functions covered by the contract... Thus, the Buy Indian Contract has not proved to be an effective mechanism for promoting a smooth and satisfactory transfer of responsibility. There is no reason, given its origin, to expect it to be." 2/

The Buy Indian Act was intended to provide employment and encouragement for Indian businesses. 3/ If contracting is to be a valid and constructive vehicle for Indian involvement and self-determination, the contracting process must be specifically designed to achieve the objective of self-determination. Under these circumstances, contracting has become too critical a process to undertake on a makeshift basis.

3. Improvements Needed

A number of crucial factors require that a tribe be given substantially more support, above and beyond what is available through the present contracting process, if contracting is to achieve a broader usefulness.

1/ 25 USC 47.

2/ University of Arizona, Dept. of Anthropology, "Contracting; A Study for the Gila River Indian Tribe."

3/ Several IHS employees complained that the tribes look at Buy Indian contracting as nothing but employment programs, not as a means for tribal involvement. The Buy Indian Act was first pushed by the BIA and IHS as an employment and economic development program. Then, when Indian government and self-determination became a goal of the federal government, the Buy Indian Act was suddenly transformed into a vehicle for self-determination. It is hardly the fault of the tribes that they are not able to keep up with the changes.

a. Long-Range Planning

Several tribal leaders indicated that they are being bombarded by suggestions from IHS to contract for this or that program. Feeling they are already swamped with contracting, they reject the offer, thereby antagonizing the IHS official, who accuses the tribe of being lazy and unwilling to assume responsibility for its affairs. Contracting is apparently being encouraged on a haphazard, ad hoc basis, by well-meaning IHS staff who have not prepared a coordinated plan for contracting with the tribes. If tribes are not going to end up either biting off more than they can chew or rejecting the whole contracting process, they must sit down with IHS and outside technical support and develop a rational, long-range plan for the transfer of programs to the tribe. The steps and obligations of IHS to support the contracting process as it develops should be specified. Also, the tribes themselves must have the opportunity to develop their goals and objectives for each program contracted for, rather than accepting whatever IHS thrusts at them.

b. Technical Assistance

The tribe will need an extensive tool-up period to prepare itself to operate any program that really contributes to self-determination. It must train staff, evaluate the existing program, determine alternative approaches for delivering the services, and plan its own approach to the new program. This will require technical assistance, both from IHS and from outside consultants, e.g., from HMO's, who can bring a different perspective to the problem. Training programs will also have to be developed for tribal personnel. An additional suggestion has been that money be provided for the tribe to hire its staff six months before the date of transfer, so that tribal employees could "shadow" the existing staff and learn essential management techniques.

c. Cost Projections

In addition to allowing adequate time for planning, evaluation, and staffing up, it should be recognized at the outset that the cost of contracting a program to the tribes increases the total cost of the program during the initial two-to-three years of tribal administration. This anticipated increase will result from several factors. First, federal estimates of the cost of tribal administration of programs, currently operated by IHS, are based on false assumptions. In a self-determination context, the cost projections allow for no major shift in the design and operation of programs under tribal administration. However, the whole point of contracting, from the tribal view, is to redesign programs and services, so as

to be more responsive to the needs and values of tribal members. Such redesign and reprogramming will require funds above and beyond current operating budgets of IHS programs. If tribes are not given funds to reshape the programs in their own image, they will be assuming the burden of running the program with very little added benefit to themselves.

A second increased cost factor is that of overhead. IHS cost figures are usually derived from line item budgets that do not reflect the substantial indirect subsidy of all such programs that results from the existence of the IHS bureaucracy and its fiscal, legal, and other departments, whose contributions to a program are rarely reflected in the line items of a federally operated program. Buildings, clerical staff, purchasing, inventory control, and the like all must be paid for by someone. Additionally, because of the government procurement system, the cost to IHS is inevitably less than it would be to a tribe.

According to one tribal chairman, if these items are not included in the contract, the tribe ends up:

> "...in effect being penalized for administering the contracted programs and services by having to underwrite the cost of administering these programs. For example, the tribe's Personnel Division must underwrite the cost of recruiting and hiring personnel to work on the program, our legal department must underwrite the cost of contract review, contract administration and dealing with other legal problems which arise in the administration of BIA contracted programs. The result has not only been a significant increase in the Tribal deficit, but also the reduction of the quantity and quality of services to the Navajo people through the diversion of tribal fiscal and human resources from other crucial activities which the tribe cannot afford to replace."1/

A third factor requiring additional operating money is that, as Dr. Johnson frequently says, "Indian tribes must be allowed to make mistakes." But mistakes cost money and, if the tribe's learning process is not going to decrease services to the Indian people, additional funds must be provided to support the tribes as they learn from their mistakes.

d. Tribal Administrative Capacities

One legacy of past policies of termination and paternalism is the absence of adequate administrative capacity

1/ Testimony of Peter MacDonald, Chairman, Navajo Tribe, in S. 1017, before the Senate Interior and Insular Affairs Committee--1973 (unpublished copy).

within tribal governments to administer effectively to the contract process. Tribal administrative structures were originally developed to perform "housekeeping" functions for tribal members, not to operate large-scale service programs. Time and resources will be required to develop administrative contract offices, so that the tribe can be a competent and equal bargaining partner when contracts with IHS are negotiated. Because they have limited capability for doing their own cost estimates, tribes usually have no resources but to accept IHS cost projections for administering a contracted program. As a result they are the captive of the IHS figures and are often "set up" for a situation that results in cost over-runs, causing the tribes to be blamed for inefficiency, lack of administrative ability and other short-comings.

Also the tribes have had little experience in dealing with the sometimes awesome burden of governmental fiscal and contract regulations. Tribes need to develop contract officers who are technically versed in contract issues, and capable of talking back to federal contract officers in the same technical language now used to overwhelm tribal negotiations. This does not necessarily mean hiring full-time lawyers. For years, the BIA and IHS have used non-lawyer contracting officers, many of them Indian.

e. IHS Role

IHS must play a critical role in negotiating a contract with a tribe and in providing it with supportive services and assistance as it learns the ropes. Given the high risks of failure for the tribes, IHS treats this role very casually. It has no staff with sole or even primary responsibility for working with the tribes as they go through contracting and operational difficulties. Contracting within IHS is handled by the AO Contract Officer, who also handles all the other procurements to which IHS is a party. He has neither the time nor orientation to be the focus of IHS assistance to tribes going through contracting. No other IHS staff person is presently in a position to adequately perform this function either; neither is it clear what role IHS will play once the tribe has launched its program.

Contracting requires a reorientation of many of IHS existing roles, but there is no indication of any IHS planning to prepare for it. In addition to endangering the tribal programs, the failure to develop a role for IHS after contracting has been implemented has created problems within the IHS staff. Since they view the whole contracting procedure as a threat to their jobs, they are not psychologically attuned to providing assistance. However, IHS will still have important services

to perform for tribes even after contracting becomes a significant reality. By developing a supportive role, IHS staff can realistically develop its own future role in supporting provision of health services to Indians. The respective roles of IHS and the tribes must be clarified so each can establish appropriate structures to perform their roles. Otherwise, the contracting procedure, at its worst, is programmed for failure and, at its best, is just transfering a program from a bureaucracy, which cannot perform the task well because it is an alien institution to the tribes and because it has not been given the administrative tools with which to do it.

4. The Jackson Self-Determination Bill (S. 1017)

The Jackson Self-Determination Bill, if adopted, will remedy many of the problems of contracting. The Bill creates new statutory authority for BIA and IHS to contract programs to the tribes. It also authorizes IHS and BIA to make grants to tribes "for planning, training, evaluation, and other activities specifically designed to make it possible for such tribal organization to enter into a contract" (Sec. 104), and "to detail members of their staff to the tribes to assist the tribes with contracting"(Sec. 105). However, the Bill does not deal with many of the problems already identified. Much of the responsibility lies with IHS--to establish its role in the post-contract phase, and to establish better mechanisms for assisting tribes with contracting and related problems.

There is, however, a larger problem with contracting that many tribes have raised--the fear that it is just a subtle and deceptive method for achieving termination of the federal-Indian relationship. The Jackson Bill states that nothing in the contracting process should be used as a basis for severing the relationship, but such a provision probably has no legal force to bind Congress. It is unlikely that there is any provision Congress could adopt that could not be revoked by passage of new legislation ending that relationship or withdrawing the funds necessary to maintain it.

For Indian tribes, their best protection is to focus on the process of contracting and self-determination and to develop a process that delineates the steps involved and structures the responsibilities of both the tribes and IHS. Structuring a clear and continuing role for IHS (and thereby assuring the continued existence of the IHS) seems to be the best guarantee that the contracting process will not lead to the termination of the federal-Indian relationship in health.

Conclusions

Contracting presents both promise and problems for Indian tribes seeking to increase their involvement in health programs. Ideally, the surest way to make a program responsive to Indian needs and desires is for Indians to take over the program and run it the way they think it should be run. But if contracting is going to be a process for Indian involvement, and not just a way for the federal government to unload some programs it does not want to administer, it will have to be done by building in protections which recognize that the learning experience involves programs that are literally life or death matters to Indian people.

II. E. COMMUNITY HEALTH REPRESENTATIVES - AN EXAMPLE OF THE CONTRACTING PROCESS

The Community Health Representative (CHR) Program is the largest program contracted to the tribes, not only in dollars and number of people involved, but also in the number of tribes holding contracts. CHR contracts are held by 256 tribes 1/ who employ 1,003 CHR's and CHA's 2/. On the surface the program has been most successful. The IHS describes it as the tribes' own program and distributes a variety of literature and public statements praising its accomplishments. Tribes, on the other hand, rarely praise the successes of the CHR program, and when they do, they praise their own CHR program, and point out how their program differs from all other CHR programs. Indians usually discuss its failures, its lack of direction, purpose, established goals, and objectives. Although the CHR program is supposed to be under tribal administration, conflicting roles are being played by IHS and the tribes as to the direction and control of the CHR's activities.

1. Background and Development of the Program

The CHR program was not a creation of the Indian Health Service. The Office of Economic Opportunity (OEO) initially funded the Community Health Aide Program in 1967. 3/ In 1969, IHS requested funds to train 250 Community Health Aides in Alaska. 4/ By 1972, the last OEO-CHR program was transferred to IHS, which has increased its support and training of CHR's to 1,003 in FY '74. IHS has held that the CHR program was created to meet four needs:

- The need for greater involvement of American Indians in their own health programs, and greater participation by Indians in the identification and solving of their health problems.
- The need for greater understanding between the Indian people and the Indian Health Service staff.
- The need to improve cross-cultural communication between the Indian community and the providers of health service.
- The need to increase basic health care and instruction in Indian homes and communities. 5/

1/ In 100 tribes plus 156 Alaskan villages.

2/ CHA's (Community Health Aides) in Alaska.

3/ Report, Meeting of Surgeon General's Advisory Committee on Indian Health, November 8-11, 1967, DHEW, PHS, IHS, p.2.

4/ The Indian Health Program of the U.S. Public Health Service, DHEW PHS Publication No. 1026, Rev. 1969.

5/ Pamphlet, Community Health Representative, A Changing Philosophy of Indian Involvement, IHS, HSMHA, DHEW, no date.

The CHR program was not initiated by the tribes, but rather was assumed by IHS to be useful in providing the tribes an opportunity to become involved in health by paying staff to perform an outreach, community organization function.

"Neighborhood workers," whatever their title (here CHR's), were, in traditional OEO style, afforded too little training and almost none in substantive areas. Had the program remained in OEO the question of function of CHR's might never have arisen and they might have continued to play a useful but ephemeral "helping" role. What was different in this case was that federal responsibility for the program passed from OEO to IHS; from the Community Action Program to the tribes themselves; and it was transferred at a time when IHS was seeking a mechanism for Indians to achieve self-determination in health.

To IHS the CHR's were an excellent vehicle to provide staff to tribes to "get started in playing a role in health." To the tribes they were something else again. CHR contracts and roles were defined in the Area Offices based on the "boiler plate" that was utilized in all AO's and rarely involved any exercising of initiative by the tribes, or helping them think through how they might utilize paid health staff.

No funds were provided by IHS for the tribes to consider the possibilities of a CHR program. Since this was the first health program for most tribes, sufficient time should have been provided for tribes to obtain background and knowledge of health programs so they could make informed decisions about how the CHR program could meet felt needs. Without such planning and training for tribal leaders to enable them to plan on an informed basis, it became much less likely that this first major experience in Indian health involvement would be a satisfying one for either party.

Typical of the services that CHR's are contracted to perform as stated in a CHR contract from the Phoenix Area are:

- Explain HSMHA health programs, policies, and procedures to the community members;
- Maintain continuous contacts with Service Unit Director, keep him informed of the overall impact and effectiveness of health programs, and attend SU staff meetings;
- Relate the expressed health needs of the community and programs in the delivery of health services to the Service Unit Director;

- Help educate people concerning the health hazards of alcoholism, cigarette smoking, improper eating habits, poor hygiene, and organize health education programs;

- Conduct courses in safety in the home, use of machinery, automotive vehicles, drug storage, etc.;

- Instruct the community in proper sanitation and maintenance of the community buildings and grounds;

- Organize communities and arrange for physicians and nurses to conduct immunization and well-baby clinics;

- Make home visits and refer people needing care to appropriate health resources;

- Offer needed transportation for people to clinics and hospitals;

- Arrange for the police to transport accident or emergency patients.

A careful reading of the "boiler plate" description of the tasks to be performed by CHR's reveals a lack of objectives or guidelines that would encourage Indian tribes to assume any role, nor is there any requirement that CHR's relate to tribal councils or local IHB's.

The Indian tribes were delighted to accept the CHR contracts. Tribal administrators did not pursue the question of what the CHR's role ought to be, nor their own role vis-a-vis CHR's. The program was interpreted as an employment program for Indians rather than an Indian involvement program, and all tribes need jobs for their citizens.

2. Implementation of the Program

From the inception of the program, the CHR's were usually without direction from the tribes or IHS. The typical IHS attitude towards CHR's was "hands off" since it considered the CHR program to be a tribal program that did not fall within IHS jurisdiction. 1/ With tribal administrators unaware of the need to offer further direction and IHS operating as though this was not their responsibility, the CHR's have floundered seeking meaningful tasks to perform.

There were a variety of useful functions that the CHR's could perform within the limitations of their sparse training. 2/

1/ Memorandum to all employees, Oklahoma City Area Indian Health Service, from Area Director, July 12, 1972.

2/ See Training Section.

Transportation is a chronic problem on any reservation and it takes no training to drive patients to and from their homes to IHS clinics and hospitals. Whether it was written into the contract or not, they performed follow-up services to patients. When Indian consumers were due for additional check-ups, the CHR's were notified. While making home visits, the CHR's would find sick persons needing medical care, and would transport them to the clinics. Since IHS has no alternative system for transporting Indians to hospitals or clinics, CHR's were trapped in the performance of this essential function. However, since the CHR program is continually being held out as an Indian involvement program by IHS the central issue is not whether transportation is a useful function, 1/ but rather whether the CHR program is a vehicle for Indian involvement, the objective which it was created to meet.

There has also been an excessive turnover in CHR personnel. Reasons cited by the CHR and IHS staff are that: (1) there are no real incentives to remain within the program, such as a progressive salary scale; (2) there is no plan or structure to promote upward mobility; (3) there is an absence of additional training in specialized areas. If these incentives had been built into the CHR program, CHR's probably would not feel that they were in dead-end jobs performing relatively unproductive tasks.

Accompanying the lack of incentives to the CHR's, except for those few tribes who feel that their CHR program is excellent, is the lack of recognition by the tribes and the communities of the potentially critical role they could perform.

Since the tribes are apparently not claiming the CHR's, not having been given the tools for defining a viable role for them, IHS has in some Areas, on its own initiative, begun to direct the CHR's. Since IHS has a voracious appetite for more staff, many SUD's and some Area personnel have begun to see the CHR's as a means of providing a supplement to IHS health staff at the Service Unit level, without the SU having to acquire slots or extra funds to pay for them. SU staff has learned that with training, CHR's can perform many health-related tasks both in the overloaded clinics and in Indian homes. Although these tasks are useful, they have little to do with the tribes utilizing "Indian contracts to expand their involvement in the health delivery system," or with fostering Indian self-determination. For those Indians who have perceived the irony, the CHR experience has made them suspicious of contracting as a vehicle for Indian involvement.

Where the CHR's have worked, it has generally been in connection with tribes who are already thinking about their role in

1/ An interagency (BIA, schools, tribes, IHS) transportation plan to serve all transportation needs on the reservation would be more efficient, and could be operated at much less cost.

health and have viewed the CHR's as a means of furthering that role. In such places, CHR coordinators are willing to take guidance from anyone willing to offer it--the local health committee, Health Boards, the SUD, or the IHS coordinators located in the Area Offices. But for the others, the tribes have had no reason to invest the time or effort to make the program work. Where CHR's were employed, they were, on the whole, performing useful tasks. Since the Indians had neither created the program, nor perceived that IHS intended "broader implications," the CHR's were not selected for their ability to impact the health system, nor were their roles structured to perform this objective.

IHS had made the not uncommon error of believing that Indian involvement would somehow occur by employing persons at the lowest salary level to perform well-meaning but ill-defined tasks. Without recognizing the implications involved in a "trickle-up model," IHS was going to help the Indians "take over IHS" from the bottom up. While CHR's on Papago and elsewhere have been able to have an impact on IHS through their day-to-day contact, it is only because they have been given strong leadership in that direction.

3. Future Direction

A number of IHS staff indicated that IHS was considering changing its official policy towards the CHR program from its present "hands-off" policy to one of more active involvement. However, if this new policy follows the practice now occurring on some reservations, where SUD's and doctors are defining the CHR's role for them and integrating them into the IHS delivery system, it will be a tacit admission that the Indian involvement aspect of the CHR program is dead, and that CHR's are just a way of supplementing IHS field health staff.

This exemplifies the problem seen throughout IHS in a number of its Indian involvement initiatives. With the Health Boards as well as with the CHR program, IHS began with a "hands-off" policy of letting the tribes independently define and develop roles. Since the tribes were being asked to do this in a vacuum, without a background in health programming or the technical assistance to guide them, the resultant weak programs certainly should have been expected. When IHS sees that the "hands-off" policy is not working, their next response is to jump in and to define the role of the tribe. While such actions might produce better utilization of manpower, it does not promote Indian involvement or give the tribes useful experience in planning and running their own health programs. IHS has not worked at the middle ground between "hands-off" and total control, i.e., assisting tribes to develop their own administrative capacity to make the program work. Where a middle ground approach has been taken, the success has been significant. This is true in the cases of USET and Papago where a strong tribal health program, supported by technical assistance from the USET staff in the first case, and HPSC in the second, was able to initiate its own health agenda, and thus make maximum use of the resources available through the CHR program.

If IHS's new policy on CHR's is to retain the CHR program as an experiment in tribal contracting and involvement, it should seek ways to encourage true Indian involvement. Rather than the SUD's and staff working with individual CHR's, defining their role and directing their activities, IHS should be working with the CHR coordinators, the tribal administrators and/or the IHB's to assist them to develop models that are meaningful both in the context of health service and tribal involvement. It should be developing mechanisms to provide them with ongoing technical assistance so that they can do the necessary planning and role development for the CHR program, and begin to consider how the CHR program fits into an overall tribal health program. Resources spent on this kind of activity would be more valuable to the concept of self-determination and to the improvement of health services in the long run than training 1,500 more CHR's who will either have no direction or be merged into the IHS staff.

A number of such mechanisms are beginning to develop. The Portland Area Health Board recently contracted IHS's administrative functions in regard to the CHR program from the Area Office. Now the funds for the CHR program go to the Board rather than to the AO. It has allocated funds from the CHR program to hire an Area CHR coordinator who works full-time to help the tribes in the Area develop their CHR program. Since the program has just begun, it is too early to evaluate, but at least the Portland Area tribes now have an ongoing source of technical assistance to help them conceptualize and operate their CHR programs and are able to understand the potential available to them.

In both the Phoenix and Aberdeen Areas, the CHR's have organized into CHR associations . Their objective is to develop a forum in which to share ideas and common problems and, hopefully, to hire full-time staff to work with the Area CHR programs. They have submitted a proposal to IHS for funding but have not yet received a response. It is not clear how these associations would relate to the tribes. While the frustration of the CHR coordinators, and their desire to get assistance wherever they can find it is understandable, it is questionable whether the CHR's should act independently of the tribes and Health Boards in developing support mechanisms. If they act independently the CHR programs might benefit substantially, but the tribes will be no further ahead in their efforts to develop the skills and experience necessary for self-determination.

Desert Willow staff indicated that they will finally be funded to provide on-site training to CHR programs. In addition to the funding problem, Desert Willow staff said that in the past they have not had a clear entry into the field because of resistance on the part of Area Offices who were jealously guarding their prerogatives and were reluctant to let outsiders from Desert Willow come into their Areas to do training. On-site training, particularly if it includes tribal administrators as well as CHR's, could also help to overcome the vacuum in which the tribes have been working. However, unless Desert Willow works with tribal administrators to define the goals of the CHR's, tribe by tribe

the provision of training will not solve the problem. Successful training takes place only when there is definition of what the trainees are being trained for, and that definition must be provided by the tribes themselves if the Indian involvement objectives of the CHR program are to be achieved.

Conclusions

There is much to learn about the utilization of contracting as a means of achieving Indian involvement by studying the CHR program; primarily, no Indian involvement will be achieved except with the involvement of the Indians themselves in the contracting process. Contracting can be utilized by Indians to achieve other goals-- an income for the tribes, employment for tribal members-- but Indian involvement means INDIANS. Indian self-determination will not come from the bottom; it must involve the Indian power structure in an important way and; wherever possible, it must also involve the Indian professional. Only where the tribe is in the position of an equal will Indians be in a position to impact health decision-making.

If the tribes are to utilize a vehicle such as CHR's, they have to understand it and be able and willing to shape the vehicle in their own image. It is unlikely that Indian involvement in health will occur simply with the formality of a contract prepared by the IHS, unless it reflects Indian input and thought and furthers Indian goals and purposes.

II. F. TRIBAL HEALTH DEPARTMENT AND AUTHORITIES

A third method being used to further Indian involvement in health is the development of tribal or intertribal. health departments. The general term "health department" encompasses a broad range of structures with varying names, departments, staffs, authorities, etc. What they all have in common is that they provide a tribe with an administrative office whose sole responsibility is health. Most tribes do not have the funds to afford their own administrative staff and specialists. Instead, three or four tribal officers act for the tribe on numerous matters including health, without having the time or technical knowledge to do a thorough job in any area. The Health Boards can only do so much on a volunteer basis without staff support. A health department gives the tribe the staff to give direction to the tribal health effort. Such a staffing arrangement need not be established by each tribe. An intertribal arrangement can either supplement or support tribal health departments by providing a central pool of technical assistance that a group of small tribes could tap, or it could go further and act as an intertribal health department exercising central authority on health matters for a group of closely related small tribes.

1. Roles and Function

There are now about 10 to 15 tribal health departments either in operation or in the planning stages. Visits were made to Navajo, Papago, Gila River, Hopi, USET and Choctaw. There was no typical structure or role. Each tribe is developing a format and set of functions that meets its own needs. The varied and creative structuring of tribal health departments is one of the most exciting and encouraging aspects of tribal activity in health. At the six sites visited some of the roles and functions that were observed include:

a. Coordinating the Ongoing Tribal Health Programs into a Single or Mutually Supporting Relationship.

Tribes are using the department concept to bring all of their tribal health programs into a cohesive, coordinated program (CHR, alcoholism, etc.). During our interviews with tribes that did not have a health department, a number of CHR and other program coordinators spoke of their feeling of isolation and lack of support within the tribe. Coordinating

the different programs into one tribal office has given the programs an administrative structure that enables them to work together on their mutual problems, support each other during crisis periods, and develop a more effective team approach to the delivery of service (e.g. the CHR's, alcoholism workers, and community development workers share information about problem families and provide services to those families as a team). This reduces their duplication of effort, extends their services, eliminates confusion to the consumers, and broadens their impact on the health of the community. Where this kind of coordination has occurred it has reduced the frustration and staff turnover prevalent in many tribal field health programs.

b. Planning and Policy Setting

Departments have been authorized to do comprehensive planning for all health services on the reservation including those operated by IHS, tribal programs, and other health services available to Indians on or near the reservation. Presently, IHS only plans for IHS, and there is no other formal agency whose jurisdiction extends beyond IHS's parochial interests. By developing plans that encompass all health agencies on or near the reservation, the health departments have the opportunity to establish priorities that take into consideration all needs and available resources to serve the Indian consumers.

c. Contracting

A health department is in a position to provide leadership in the contracting of health programs to insure that the expansion of tribal health activities is orderly and not destructive of cultural values that the tribes want to maintain. (For example, the Choctaw Health Department is overseeing the Tribe's program to assume operational control of its new hospital, once it is completed.) It is in a position to develop an overall plan so that contracting occurs at the pace the Tribe deems appropriate. By this method, the Tribe will have an opportunity to investigate its alternatives and develop a tribal model before it assumes operating responsibility. In addition to the ones IHS has offered them, the departments have also begun to seek contracts for tribal health programs, such as programs for the elderly, which expand the range of services available on the reservations. With decentralization of authority for these programs to HEW regions and thence to the states, tribes are finding it difficult to obtain such grant money, but tribal health departments are aptly situated to perform that role.

d. Staffing the Tribal Health Board

The department staff are also serving as staff to the tribal Health Boards, providing them the backup support and technical expertise the Boards need in order to deal with IHS as equals.

e. Developing Health Manpower Programs

Tribes have had increased experience in running their own manpower programs, but have had little experience in health manpower. Some departments have assumed the role of coordinating for tribal health employees and encouraging students to pursue careers in health. They are also preparing to take over training of both professional and allied health professional staff for positions in IHS and elsewhere.

f. Representing the Tribe on All Reservation Health Matters

IHS has tended to be the spokesman for health on most reservations. As tribal health departments have developed they have been able to assume this role of developing policy positions on health issues, permitting the tribes to advocate an Indian health position independent of IHS. They are also assuming the responsibility for preserving the traditional health practices and medications, a role which belongs most appropriately to the tribes.

g. Interacting with IHS

The departments are also developing new and different relationships with IHS. At Choctaw they are planning to take over many of the programs IHS now operates. The Navajo Health Authority has no formal relationship with IHS, though when it develops its comprehensive plan it will apply for funds from IHS as well as from all other health delivery resources. The Papago Executive Health Staff serves as the SU heal oard, setting general policy for IHS, and coordinates its programs with those of IHS into an integrated operating system. USET, rather than contracting for specific health programs, is contracting with IHS for planning, training, and certain other administrative functions of a number of health programs.

2. Funding

The funding for the health departments has come from a variety of places. Navajo has received a grant from IHS, as well as a 314(b) comprehensive health planning grant from HEW. Papago utilizes the coordinators of each of the tribal health programs as the health department staff; their salaries are covered by the individual programs they operate (CHR, alcoholism, etc.). They also have an IHS employee detailed to them to provide additional staff capability. USET's funds come from contracting staff positions from IHS to perform tasks formerly the responsibility of IHS. Other tribes are using staff, hired to perform evaluations for IHS, who also serve as health department staff. Other tribes have staffed their departments through funds received from IHS Community Development funds.

The last source is the most common method of funding, but is limited by the relatively small amount IHS has available for Community Development programs. However, both the Community Development fund and the creative funding techniques used by other tribes are too sporadic and undependable as sources of funds to enable tribes to build a sound health administrative system. A more reliable source of funding is needed so that tribes can have the feeling of permanency in the process and so more tribes can avail themselves of the opportunity. Tribes cannot be dependent on the whim of IHS Area Officers who may or may not support an independent tribal health department. In order for the tribal health departments to be able to relate on an equal basis with IHS, their source of funding must be a matter of right rather than subject to a yearly review where their activities can be vetoed by IHS.

3. Future Development

The three most developed tribal health departments visited for this study (Navajo, Papago, and USET) were impressive examples of what can be done. (Each is described in detail in the next Section, "Three Tribal Models.") There seems to be no simple formula which accounts for their accomplishments. They all represent a mix of several strong individuals with a deep interest in tribal health problems, good tribal support, good technical and back-up support, and many of the intangibles that promote an atmosphere in which a new program is likely to flourish.

They represent the first generation of tribal health departments. The next generation consists of those that IHS is funding through its Community Development funds to enable other tribes to get started--Hopi, Gila River, Warm Springs, etc. In deciding which tribes to fund for health departments, IHS indicated that it was looking for a number of factors, the most important being strong involvement by a key individual or individuals and good tribal support. An attitude expressed throughout IHS was that when and if a tribe reached the point of being able to demonstrate that it was ready to run a health department, IHS would respond with funds--even if it had to scrape them together from places other than the Community Development fund. One of the strongest points in IHS's program was its proven willingness to respond to a tribe once the tribe could convince IHS it was ready to move.

The new health departments will have funds for both staff and operations and strong leadership supporting their effort in health. It is not clear, however, where they will obtain the technical support to assist them to develop their own unique model of a tribal health structure. One of the common factors among the first three programs was the ready and ample availability of technical assistance, particularly health expertise, from the Health Programs Systems Center (HPSC) and the University of New Mexico Medical School. The technical support played a significant role in helping the first generation of programs to evolve their own unique approach. Similar support will be essential for the second generation. The erratic support available through the AO's has not yet provided the kind of sensitive, continuing support so essential to an emerging health department.

One of the surprising aspects of the first generation of health departments is that none of them developed a "standard" model of a health department; that is, a tribal health director with some staff working with a tribal Health Board. One possible conclusion is that the vitality and success of a health department is its suitability for the particular tribe that designs it. The second generation of health departments appears to be adopting a more standard model. Given the experience of the already established departments, it might be advisable for the Hopi, Warm Springs and other tribes which are embarking on the establishment of a health department to create a model that is uniquely theirs. This takes time and money and it is unlikely that HPSC will be given the funds to offer support to tribes around the country. Therefore, either the AO's are going to have to sensitize their own staff to perform these functions or tribes will have to be given money to bring in their own outside technical assistance.

4. Intertribal Arrangements

In several Areas, the Area Health Board is acquiring staff capacity. Such Boards could easily be developed into sources of technical assistance to their own tribal Health Boards, and also to perform the tasks that USET is now performing--helping the tribes develop health departments and assert greater control over the SU programs on their reservations.

Since most of the existing knowledge on tribal Health Boards comes from the experiences of the three first generation programs, the next section provides a detailed picture of each of the three: The Papago Executive Health Staff, the Navajo Health Authority, and United Southeastern Tribes.

II. G. THREE TRIBAL MODELS OF HEALTH DEPARTMENTS AND AUTHORITIES

1. The Papago Executive Health Staff

The Papago Executive Health Staff (EHS), a department of the Papago Tribe, is composed of the six directors of the six tribal health programs 1/ who work together as a unit (the EHS) to operate and maintain an overall tribal health organization (in addition to working separately to run the individual programs that they administer). The members of the EHS also sit as the SU Health Board. The EHS sets overall health policy for the reservation (including IHS), runs a coordinated tribal health program, initiates new health programs on the reservation, and impacts the IHS program from two directions: as members of the SU Health Board they set specific policy for IHS, and as tribal health program directors they and their staff work daily with IHS on a variety of health matters and thereby affect IHS attitudes and operations.

Unlike USET, the EHS is not taking over programs or functions now performed by IHS. Nor are they like the Navajo Health Authority which does not want to become involved in the operation of health service programs. The EHS approach is to develop a strong tribal health presence, by setting reservation-wide health policy and by operating programs that function alongside of IHS. They view IHS as a valuable and continuing resource for which they should set policy, and with which they operate their own programs.

a. Formation

The EHS was not a pre-planned model but developed organically out of a series of crises on the reservation: the collapse of the SU Health Board, and, more serious, the sudden death of the tribal chairman in a plane crash. At that time the present members of the EHS were individual heads of their different programs, operating as separate entities, with little knowledge of each others' programs. They began working together to support each other during these crises. With on-going technical assistance from their SUD, HPSC, and a consultant from the University of California School of Public Health, they began meeting together regularly to discuss how they could organize a tribal health structure. Their objective was to develop a structure that was in harmony with their Papago culture, rather than simply adopting a typical bureaucratic structure which they felt was unsuitable and unworkable in a Papago environment. As they worked on evolving a structure, they also began informally to work together on program issues, helping each other on specific problems and developing overall health strategies. As they worked together regularly for over a year, they began to identify some set patterns in the way they were interrelating. With the help of the technical consultants, they put

1/ CHR, Emergency Food and Medical Care, Nutrition, Mental Health, Alcoholism Prevention, and Disease Control.

their patterns down on paper and found that an organizational structure had evolved naturally out of their continuous interaction. Rather than having squeezed themselves into an existing structural model, they had developed a model which reflected their own way of doing business. As they subsequently realized, this also reflected the traditional Papago way of structuring relationships.

Traditionally, the Papago Tribe did not operate under a highly stratified governmental structure with a hierarchy leading to the top. Tribal problems were dealt with through meetings of the village heads, with no formal structure or leadership. Rather, a leader would emerge to deal with a particular set of issues and then merge back into the group when the problem was solved.

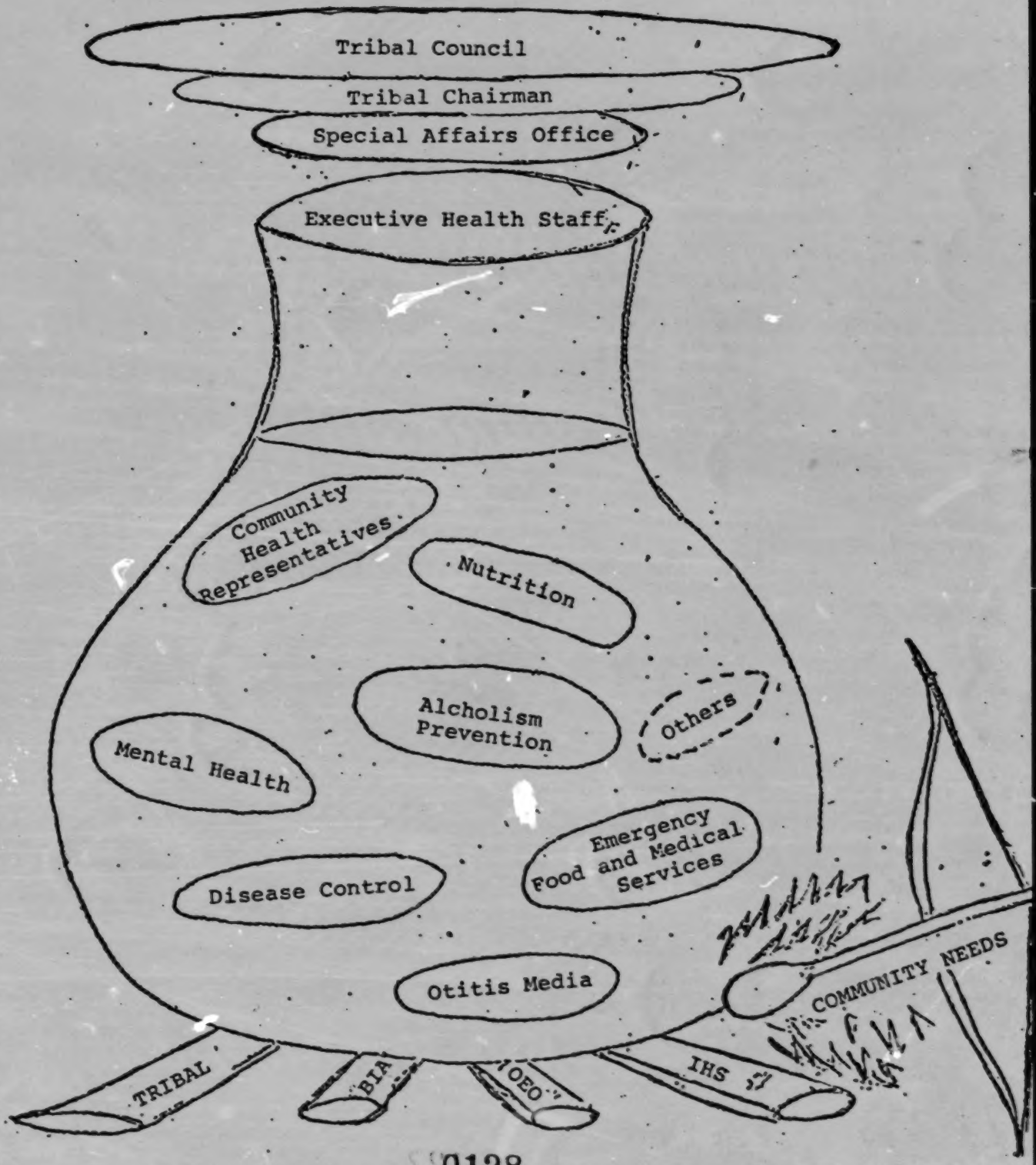
b. Structure

The Bith Haa model (the name the EHS gave to the structure that had evolved) under which the EHS now operates is described below:

> "The 'health organization' is contained and kept in delicate balance within the Bith Haa (a clay pot used by Papagos for cooking). See Figure i. The vessel contains the health components, represented by the various directors. Each component retains autonomy within its own program but is bonded with one another by the common goal of operating and maintaining a coordinated or unified Tribal health organization that is Papago-oriented.
>
> "The Executive Health Staff responds as a total unit to health programs and issues as they arise. As new health programs develop they become part of the Bith Haa.
>
> "The Bith Haa model provides leadership evolvement in this manner. When a problem or issue surfaces, the Executive Health Staff deals with it by either acting as a total group or by designating one or more representatives to act for the group. This representation will vary depending on the type of problem and the kind of expertise required at that time. In this manner there is a skills bank within the group that can be pooled or called upon to handle situations more appropriately.
>
> "The Bith Haa model does not exclude persons other than the current Executive Health Staff. The model allows other groups or individuals to come into the Bith Haa and become intermittent or temporary participants if the situation demands it. For example, a technical consultant in a specialized area may enter the group if that expertise is necessary for a wiser resolution or evaluation of a particular problem. This increases the group's productivity and allows it to have a reserve skill bank.

Figure i

"BITH HÄÄ" MODEL



"There is no 'fixed group leader' or 'chief.' There are spokesmen. The leadership is in the total group. There is an office--health affairs or special affairs office. This office is functional and the appointed spokesman or spokesmen assume that office whenever the need arises. The representative will vary depending on the situation.

"The Bith Haa model demands continuous dialogue among the various components so that coordination and a focused approach that is Papago-oriented is maintained. With this type of structure, each director must assume full responsibility for his particular program operation. The group responsibility is felt and carried by its members, for each one is aware of the responsibility and decision-making role it has and the implications and effects for the entire Tribe.

"The Executive Health Staff is under the Executive Officer of the Papago Council and acts in behalf of the Tribe in initiating analyses of health issues and managing, coordinating, and administering Tribal health programs. It advises the chairman of the Papago Council or, if necessary, the entire Papago Council and makes recommendations or takes direct action on health issues. The Executive Health Staff does have a chairman, a liaison officer selected by the Executive Health Staff, and a Tribal health advisor who are primary contacts for daily operational functions.

"The role of the Federal agencies is to provide the fuel to the Bith Haa in terms of monies and/or human resources so that the Bith Haa can be the vessel in which the "nutrients" are developed to actualize programs to meet health needs.

"The health needs of people or communities are the flamed match that ignites the 'fuel' so that the whole process is started and continued, through the Bith Haa as diagrammed." 1/

c. Funding

The salaries of the EHS staff are paid by the programs they individually head (CHR, Alcoholism, etc.). In this way the individual tribal health programs are absorbing the costs of the EHS and thus indirectly providing for the costs of tribal planning and coordination that are not directly provided for in the individual contracts between the tribe and IHS, NIAAA, NIMH, etc. The EHS does receive funds from the IHS Community Development Fund, which is used to pay for staff training, conferences, consultants, and similar self-development expenses. It also has an IHS staff person on detail who works full time on EHS issues, but

1/ Report to the Tribal Chairman of the Ad Hoc Committee for Papago Health Organization and Related Activities, May 15, 1972.

in the capacity of a resource and liaison person and not as the head of the EHS.

d. Functions

Planning and Program Development

The EHS performs a variety of health-related functions. They set overall health policy for all the health programs on the reservation, including IHS and they plan new programs. This past year they set the overall health goal as "harmony." They develop their programs around the goal, and so does IHS. For IHS, the EHS determined the goal to be increased harmony between the system and the Papago consumers by improving the way patients are treated in the outpatient clinic. For the Community Health workers it has meant improving the physical environment of the reservation to make it more attractive and to reduce health hazards. They are working to develop new health programs such as programs for the elderly and food stamps, and to find new health resources such as money from state revenue sharing and Hill-Burton funds. They also act as advocates for more health resources for Indians at the national, state and local level.

Service Unit Health Board

EHS had not originally conceived of becoming the S U Health Board. This role evolved once the tribal health department was well established. It is a unique way of dealing with the Health Board concept, since rather than being a grassroots consumer board, they are health professionals who deal with IHS on a professional level. This presents many advantages and a few disadvantages.

As health professionals and tribal health policy-makers, they are in a much stronger position to play a policy-setting role for IHS. They have worked with the SUD to apply reservation health goals. They presented the outpatient clinic problems to the SUD, and he is now working on them as his number one priority, reprogramming resources to outpatient services. They have also approved several experimental projects HPSC wanted to run on the reservation but only after making HPSC revise its plans to make them more compatible with Papago thinking. They also participated in the selection of the SUD, insuring an individual whose thinking was compatible with theirs. Since both the SUD and the EHS agree on the importance of emphasizing outpatient problems, they avoid the problem observed elsewhere--of the SUD agreeing to Health Board priorities and then activating his own priorities. EHS also participates in the selection of the doctors, which they feel has improved the morale of the doctors, though there are still major gaps between the doctors and the community that must be bridged.

They feel that because of their day-to-day involvement with IHS as health professionals, they have forced surfacing of many problems which might not have arisen had their only contact with IHS been at monthly Health Board meetings. The SU staff also feel

that the presence of the strong and active EHS, in both its operational role and Health Board role, insures continuity to IHS programs. In the past, programs started by a SUD or doctor would die as soon as he left; now the EHS is able to insure continuity. IHS staff indicated that the existence of the EHS provided a useful outlet for gripes they had against the Tribe or individuals, and the EHS meets once a month to hear complaints of individual consumers against IHS.

The EHS has also worked to make IHS more culturally sensitive. Due to the circumstances of their creation, they are aware that Papago methods of operating can also function very effectively within a Western health context, and are working to influence the IHS system to adopt methods more compatible with Papago ways. They also feel that the day-to-day contact between their tribal health program staff and IHS staff gives IHS a cultural awareness that would not have come if their only contact had been on a policy-making level. This has also worked to make the Papago consumer see health as not just IHS, but IHS plus their tribal health programs, which makes the Papago consumer feel more comfortable and less intimidated by IHS.

The problem with health professionals on the Board is that they could lose their ability to see the consumers' side of problems and instead begin to empathize with IHS as one professional to another. The EHS indicated that they were aware of the potential problem but did not necessarily see it as a conflict of interest. They make regular visits to the Papago villages to meet with the consumers and to report on what they have done, thus keeping themselves abreast of consumer concerns. From observation it appeared that they were extremely conscious of the fact that first and foremost they represented the Papago consumers and were answerable to them.

e. EHS View of Contracting

For the future they have no plans to contract the health services IHS is now providing. They see IHS as one health resource among many that should be made available to Papagos. They plan to have the Tribe become more involved in the delivery of health services, but this would not be by taking over programs now operated by IHS, but rather by starting new programs that neither IHS nor the Tribe are now providing, such as programs for the elderly, halfway houses, etc. They also feel there are some unexplored potential dangers in contracting programs from IHS. They are concerned that contracting, as presently constituted and as it increases, will give IHS a hold on the tribes since it gives them control over the money tribes will need to run their programs. They are concerned that IHS will use the threat of cutting down on contract money to push tribes into positions not compatible with the tribes' thinking. They also feel that tribes have to be more aware that everything with a dollar sign in front of it is not necessarily good, and that tribes will have to learn to select funding and advice that is compatible with their own culture, or produce a product not in harmony with the tribes' goals.

f. Applicability of the Papago Model to Other Tribes

The EHS staff cautioned against taking their model and trying to apply it wholesale to other Service Units. The Bith Haa model is a unique response to Papago needs and culture and may not fit other tribes. However certain components of it, such as the close working relationship of the different tribal programs to create a health mechanism that is synergistic, i.e., bigger than the sum of the individual programs, or the use of Indian professionals on the SU Health Board could be useful starting points for other tribes trying to develop their own unique approach. They feel that what could be more useful to other tribes is the process they used to develop a structure that is appropriate to their culture--the process of meeting, talking and working together with the assistance of technical experts.

But they also recognized that this process takes time, staff and money which must be made available to other tribes as it was to them. The technical assistance regularly available from HPSC was a key factor. As long as other AO's can only provide assistance to the tribes on a sporadic basis, other tribes will be working under a significant handicap in trying to utilize this process.

2. Navajo Health Authority

A distinctive model health department has been established by resolution of the Navajo Tribal Council. 1/ The primary impetus for the creation of the Navajo Health Authority (NHA) was the lack of adequate health care, the need for comprehensive planning and development leading to an exemplary health system, understaffing, and the limited number of Indian personnel in professional and paraprofessional positions employed by IHS. According to the plan of operation, the health authority was organized for the following purposes:

- Establish and operate a Center for Health Professions Education that will develop and implement the establishment of an American Indian Medical School and training programs for all health professions and allied health professions.
- Provide long-range comprehensive planning, evaluation, and development appropriate to the full development of an exemplary health system for the Navajo Nation.
- Coordinate, develop and/or cause to be developed to their maximum potential and utilization, all appropriate and available resources of the Navajo Nation, the federal government, the various states and other agencies, groups or individuals meaningful to the improved health education of the Navajo people; and develop and promote the full utilization, preservation, education and practice of the Navajo healing sciences appropriate to the future health education of the People.
- Interpret and distribute data, which accurately describe the health status and needs of the Navajo people, and establish and maintain an American Indian Health Library.

The NHA Board of Commissioners, which consists of eleven to twenty-five members, all of whom are appointed by the Chairman of the Navajo Tribal Council and confirmed by the Council's Advisory Committee, is very unique in its composition: 2/

1/ CJN-44-72, Resolution of the Navajo Tribal Council, Establishing the Navajo Health Authority, approved June 2, 1972. See also Resolution 4R-1, Navajo Health Authority, Statement of Goals, Functions and Philosophy, printed March 1973.

2/ Navajo Health Authority, Plan of Operation, 1973.

a. One-half of the Commissioners are members of the Navajo Tribe who speak English with fluency and who have sufficient education, experience and dedication to the improved health of the Navajo people as to qualify them for such leadership and for making sound judgments.

b. One-half of the Commissioners are persons having not less than ten years' experience or professional training and education in health or health-related affairs, planning development, education operations or administration. 1/

c. The Board includes persons possessing the following qualifications in addition to their being qualified under a and/or b above:

(1) membership in the business community;
(2) an American Indian not of Navajo heritage;
(3) membership in the legal profession;
(4) a president of a university or college within the boundaries of the four adjacent states;
(5) a present or former professor of medicine at a recognized school of medicine;
(6) a practicing physician;
(7) a registered nurse;
(8) a member of the Navajo Area Health Advisory Board;
(9) a hospital administrator; and
(10) a Navajo practitioner of the healing arts.

The composition of the NHA Board reflects not only a sensitivity to the array of tribal and community interests relative to the goals of NHA, but in addition a sensitivity to the professional disciplines of both Western and Navajo cultures. Another distinctive feature of NHA is its total independence from the Indian Health Service and its autonomy from the Navajo Tribal administration. Although there is contact between NHA and IHS and discussion of program ideas and problems in the delivery of health services on the reservation, NHA was not created to replace IHS or to usurp any of its functions. For NHA, IHS is one of a number of health service delivery resources available to the Tribe in developing their model health care delivery system.

Similarly, NHA was not created to replace or usurp any of the functions of existing Health Boards and committees. Its goal, as the mechanism for tribal input into health care

1/ This includes Navajo practitioners of the healing arts (who legally might not qualify under part a), two of whom are on the Board.

delivery on the reservation, is future-oriented--to design a model health care delivery system--and it does not propose to impact on a piecemeal basis ongoing programs or services, or to disrupt the roles of existing Board mechanisms. In addition, NHA is the only mechanism on the reservation which has a mandate for comprehensive planning--taking into consideration all resources available to the Tribe,e.g. private hospitals and other health resources, colleges and universities, state and local governmental resources, and resources available through health insurance and prepaid health programs, as well as IHS and tribal health programs.

NHA was not created to assume administrative responsibility for any components of the existing health delivery system nor to operate new components. When the CHR program requested that it be placed under the administration of NHA, the request was denied because NHA involvement in any aspect of program administration would deter it from its primary goals. NHA sees itself as a change agent that will radically impact the concept of health care delivery within the Navajo Tribe. It proposes to <u>design</u> a model health care system and to <u>assure</u> the development of the mechanisms and the manpower through which the system will be implemented, but not to operate hospitals, clinics or other health delivery programs.

The decision to keep NHA free of operational responsibilities was taken deliberately and consistent with the view of the Board that the roles of comprehensive planning and change agent are mutually exclusive with operating component parts of the health delivery system, at least at this time.

<u>Health Manpower Development</u>

Development of Indian health manpower is viewed by NHA as a primary vehicle for achieving self-determination in the delivery of health care services and markedly increasing the cultural sensitivity of personnel and health program systems. The thesis is a simple one--that given appropriate training, Indians would be best suited to staff all positions within the health care delivery system--as practical nurses, as physicians, and as Area Directors.

NHA is operating under an $800,000 grant from the former Bureau of Health Manpower Education, NIH, through the University of New Mexico School of Medicine to establish an Area Health Education Center (AHEC) under NHA. The AHEC provides the basic resources for developing health manpower within the Tribe including training programs, training and scholarship support, outreach and recruitment at the high school and undergraduate levels for individuals to pursue careers in the health occupations, internship and externship programs, job placement (not only in traditional health occupations but also in emerging paraprofessional and allied health occupations) and the development of native practitioners.

Several offices have been established under the AHEC 1/ but of particular note is the Office of Native Healing Sciences whose major objective is to sensitize health personnel to cultural and health issues from the Navajo perspective, to preserve the art of native healing practices, and further the understanding and use of Navajo medicine. Although Western medicine has much to offer the Indian, many of the concepts and practices inherent in Navajo medicine are not only valid, but in some cases, more effective in treating specific types of ills encountered by Navajos. Thus, the Office of Native Healing Sciences is charged with the responsibility for cataloging medicinal herbs, Navajo diagnostic processes, and the practices of medicine men to preserve these healing arts, and for developing training programs to perpetuate them as valid approaches to healing. In addition, the Office is preparing a roster of Navajo diagnosticians and medicine men for use in referral of individuals who desire native healing practices. Referrals to Navajo practitioners are made by Western physicians (IHS and others), and the Office of Native Healing Sciences proposes to train these Anglo physicians as to how native healing practices can complement or be utilized in lieu of "modern" medical treatment. Similarly, native practitioners would be trained as to the advantages and limitations of Western medicine. The Office is cooperating with the Sioux Tribes in developing these programs.

1/ (1) Office of Student Affairs; (2) Office of Native Healing Sciences within the Navajo Health Authority; (3) Office of Health Education; and (4) Office of Emergency Medical Services. "First Annual Report, the University of New Mexico, School of Medicine, Area Health Education Center," October 1972 to September 1973.

Part of NHA's health manpower thrust has been to establish the concept of a medical school and health scholarships for all Indians, regardless of tribal affiliation. Although the medical school concept is not fully formulated, it will significantly differ from traditional medical school concepts. Not only will the medical school be concerned with training Indian physicians, but it will also play a major role in training Indian health-related personnel including paraprofessionals and allied health workers. Current plans envision utilization of existing hospitals and clinics as sites for practicum training as part of the medical school program and an externship/internship program for Indian health trainees at all levels. NHA staff expressed the feeling that the concept of a pan-Indian medical school will produce effective, culturally sensitive, Indian-operated health care. It is anticipated that the medical school will be funded by 1976.

Comprehensive Planning

In July of 1973, NHA became the only tribe to receive a Comprehensive Health Planning (CHP) grant 314(b) from the Health Services Administration, HEW. These grants are designed to provide the resources to establish an agency whose sole function is comprehensive health planning for a local geographic area. At the time of UAI's interviews with NHA, the Comprehensive Health Planning Agency (CHPA) had not been established and the advisory committee required by the grant was in the process of formation. The CHP Advisory Committee would take on the task, along with NHA, of designing the CHP, determining comprehensive planning strategies and priorities, etc.

One of the most important capabilities provided through the CHP mechanism is to enable the Tribe to develop a comprehensive health plan which takes into consideration all resources, including those potentially available to the Tribe, but currently not in the Tribe's existing health delivery system. Thus, the planning process at once becomes more comprehensive and opens the possibility for significantly expanding the amount and quality of health services available to the Tribe. By developing an independent Tribal planning mechanism without limitations in its mandate, it can redesign the uses of those monies available to eliminate duplications of service and shift priorities so that funds are allocated consistent with predetermined priorities based on health care needs.

The advent of the CHP will, over time, shift the locus of planning from IHS to a tribal entity. Planning in this context will more sensitively reflect tribal viewpoints and should result in significantly greater cultural sensitivity of services to the consumer. The CHPA should also provide an excellent mechanism for assuring that the resources developed through the AHEC, the medical school and through tribally-administered programs such as the CHR program, will be optimally utilized within the framework of a fully integrated, comprehensive health delivery system.

UAI's interviews with IHS staff, as well as NHA staff, uncovered some sensitivities within IHS with regard to "encroachment" and "usurpation" of IHS's role and authority through the CHP. However, from the long-range point of view, the CHP (assuming it is effective in carrying out its mandate) should significantly enhance the effectiveness of the IHS program by supplementing IHS resources with other resources which CHP can integrate into the health care system, and ultimately reducing the shortfall between the resources (as opposed to dollars in the IHS budget) required to provide adequate services to meet consumer need.

Notwithstanding the fact that the Navajo Tribe is frequently able to capture planning and developmental funds out of proportion to many other tribes, there are valuable aspects of the NHA model which are replicable by other tribes. Perhaps the most impressive aspect of the NHA model is the sophistication of NHA's concept of self-determination in the context of health care delivery. NHA has taken the position that self-determination in a health context must first and foremost mean the availability of trained Indians at all levels to perform all functions, from planning to staffing all professional and non-professional positions within the health delivery system. No matter how much administrative control the Tribe might obtain over health delivery mechanisms, cultural sensitivity of programs and services would still be seriously limited until Indians are planning for and serving Indians.

Secondly, the Tribe realizes that to take over administrative control of existing programs without redesigning them to more effectively serve the needs of the consumer population would be self-defeating. Thus, NHA recognizes that comprehensive planning must precede any plans for administrative control, should that become a desirable end. NHA, having looked at the possibility of recommending that the Tribe assume administrative control over IHS components, has taken the position that the issue is not a priority one at this time and will not become a relevant consideration until Indian manpower has been developed.

One of the problems seen with NHA was the proliferation of health agencies on Navajo. In addition to NHA and CHP, the Tribe has Service Unit and Area Health Boards, a Tribal Council Health Committee, and a variety of tribal health programs. There seem to be overlapping functions and the lack of a clear understanding of how these different health organizations relate to each other. For example, the health boards were not sure what their relationship to NHA should be, and particularly not to CHP. There also seemed to be no coordination of training programs or other resources among these organizations, causing an expensive duplication of effort. It is possible that coordination will have to await the implementation of the comprehensive plan by the CHP. Tribes without the resources available to Navajo might not be able to affort such duplication and might feel the need for greater impact in a shorter time period.

3. United Southeastern Tribes (USET)

Introduction

USET was organized under tribal initiative (Cherokee, Choctaw, Seminole and Miccosukee) and incorporated in 1969. The primary impetus for the creation of USET was the recognition that each of the individual tribes was too small to capture sufficient funds to minister to its various needs at a tribal level; each tribe recognized that program planning, administration, and operation would be more efficient if done on a collective basis; that quality control would be more feasible on a collective basis; that each member tribe could realize synergistic benefits in dealing with the federal agencies through an intertribal mechanism; and that each was committed to self-determination which could be more effectively implemented through an intertribal structure.

USET is the intertribal mechanism for the participating tribes, which since USET's incorporation now include the Seneca Tribe, which is a member, and the Couchatta and Chitimacha Tribes, which are served through a loose affiliation with USET, since they are not formal members. There are eight separate program entities under USET, each individually staffed. They include such program areas as manpower, education, and economic development. The IHS component is the most recent program area to come under the USET umbrella. USET serves a population of approximately 20,000, although IHS officially recognizes a population of only 9,200.

The USET Board consists of three representatives per tribe. Typically, the three representatives are the tribal chairman, a member of the tribal council and a "representative" community leader or consumer. There is also an Executive Committee of the Board, composed of the tribal chairmen, that is very influential in developing overall policies and in guiding the development and operations of USET.

The initial impetus for a decentralized health component in USET came around 1970-71. There was considerable concern on the part of the tribes that because the IHS Area Office was located in Oklahoma City, the USET-affiliated tribes had become the step-children of the Area Office, receiving less than their fair share of service funds, technical support and overall attention from the Area Office. Ultimately, this concern was taken to IHS in Washington, specifically to Dr. Johnson, Mr. Chadwick and the Community Development (CD) office. The IHS Director and his Deputy believed that there was justification to the complaints of the USET tribes and it was decided that a kind of mini-Area Office would be set up in Sarasota, Florida, to deal directly with the USET tribes. The Oklahoma City Area Office would continue

to provide administrative support services such as bookkeeping and supply services and the Sarasota Office would deal with program issues including program planning, budgeting, administration, monitoring, and tribal concerns.

After a year under this arrangement, the tribal chairmen became disenchanted with the Director of the Sarasota IHS office. Tensions built and ultimately there was a confrontation meeting with IHS in Washington at the insistence of the tribes. The meeting resulted in a decision to remove the Director of the Sarasota IHS office immediately and to contract portions of the program to USET. The two most significant outcomes of the meeting were a decision to permit the tribes to exercise their right of self-determination and the tribes' recognition that they had some power. The latter issue was significant. Staff members repeatedly commented on their power in replacing the Director of the IHS Sarasota Office with a man of their own choice. In the view of the UAI interviewers, psychologically, the meeting of August 31, 1972 in the IHS Headquarters office was probably the single most important event to convince the tribes that they could affect the delivery of health services to their members.

Structure and Functions

USET's health component is still in the developmental stage. It has been restricted in its ability to develop a clear structure without separate funding. USET health input depends upon staff funded under a few specialized contracts, one training contract and one mental health contract. USET will be in a stronger position to shape and flesh out its structure when and if it obtains funding that is not tied to specific programs.

At least in the area of health, USET is viewed by the member tribes as a service and support arm to the individual tribal operations. Conceptually, USET is not expected to impinge upon tribal sovereignty. Decision-making authority rests with each tribal council and tribal chairman.

The self-image of USET is that its role should be planning, technical assistance, training, monitoring and evaluation--but not program administration. It is interesting to note that USET's contract with IHS provides little definition of USET's role. This lack of clear definition at the outset was intentional, at least on IHS's part, in order to provide USET the opportunity to evolve its own role. However, there is some feeling (albeit not well-defined on the part of some USET health staff) that eventually USET will have to assume some administrative responsibility if it is to realize its full potential on behalf of the member tribes.

USET is presently working on three specific projects: 1) to identify health training needs to develop plans for obtaining training; 2) to recruit Indian manpower for health positions; and 3) to provide technical assistance to alcoholism programs operated by the USET member tribes. While carrying out these functions it is assisting the tribes to develop their involvement in health and vehicles to control their health delivery system. The tribes and Service Units in the USET Area are more aware of Indian self-determination in health than is true elsewhere.

Because the USET health component was relatively new at the time of the UAI interviews, activities such as comprehensive planning, staff training at the Service Unit level, evaluation, and recruitment of Indian health manpower were still in the developmental phase. No formal evaluations of the SU's had been undertaken by anyone. A "Service Unit Review Team" consisting of IHS staff, the Director of USET, and tribal people (unspecified), was proposed for "review" of the activities of the SU's beginning in the spring of 1974.

Comprehensive planning is not yet a reality within USET. This is partly because USET's mandate is not clear vis-a-vis the autonomy of each of the member tribes. USET staff felt that they needed more time to develop a clear approach to comprehensive planning, more time to establish relations with the individual tribes, and to develop sufficient rapport so that USET could adequately comprehend and reflect the tribes' concerns in any comprehensive planning effort. There was still the need to distinguish the roles of USET on the one hand, and the IHS Sarasota Program Office, on the other.

There was considerable lack of clarity concerning the degree to which USET actually determines policy and its role in the planning process. The Sarasota IHS Director freely states that he works jointly for the IHS and the Director of USET. His responsibility to the Oklahoma City Area Office is virtually nil. Although the Sarasota Program Director states that he receives policy guidance from the Director of USET, there was little evidence of it. Rather, the relationship appeared to be more informal than formal, and USET and IHS to a somewhat lesser degree, are still defining their roles. On the one hand, there appears to be a reluctance on the part of USET to take a more aggressive posture with the Area Director and, on the other, a reluctance on the part of the AD to take the initiative in working with USET to define more formal and precise roles for each.

USET's Relationship to IHS

One of the most striking features about the USET operation was the lack of communication and interaction--even contact--between USET staff and staff of the Sarasota IHS Program Office. Contact between the Program Office and USET seemed to be limited solely to informal contact between the USET Director and the Program Office Director. No system had been established for regular meetings between the two staffs, although the AD attended "most" of the USET Board meetings, nor was there a mechanism for regular contact by the two staffs below the Directors' level--not even to initiate exploratory dialogue. In fact, during the first of the two field visits by UAI staff the first meeting between the two staffs occurred and the first exploratory planning session involving those below the Directors' level took place.

Although both USET and the Program Office occupy offices in the same bulding, the separation between the two was most evident. An interviewer visiting both the USET and the IHS Area Office could not help but notice that the former was staffed by Indians (except for the secretaries) and that the latter was staffed by whites (except for the secretaries). This was clearly a point of sensitivity to the USET staff, many of whom expressed the fact that there was resistance to the implementation of Indian preference by the Program Office.

USET and the Program Office maintain separate contact with the tribes and make separate field visits to the Service Units. The two programs operate independently of one another, and one could not help but wonder as to the impact at the local level resulting from this uncoordinated duplicative "technical assistance" being offered competitively to the tribes.

Although the Program Director was most emphatic in stating that he worked for the USET Director as well as for IHS, he offered no concrete examples when asked to describe how this dual administrative accountability worked in practice. Moreover, when pressed for examples of how USET could play a more direct administrative role, he took the position that PHS personnel could not legally work for non-governmental administrators since this would be illegal, though he subsequently acknowledged that such an arrangement could be made possible through contracting the Service Units to the tribes. Several staff members expressed serious concern as to the real intent and motives behind the Program Director's surface support for self-determination through USET. The USET staff impressed both UAI interviewers as being a unique concentration of bright, competent and committed Indians, but under the circumstances they were being underutilized and depleting their energies since their authority was ephemeral and their role unclear.

There are three IHS Service Units within the USET tribes: Cherokee, Choctaw, and Seminole-Miccosukee. (The Couchatta and Chitimacha tribes receive all of their services through IHS contract services.) All three SUD's are Indians who were appointed with the approval of the tribes and who work closely with the tribes on health matters. There also seemed to be a much stronger feeling among the SU employees than elsewhere in the IHS system that their primary constituency was the Indian people and not the IHS system. There was a feeling among USET staff, however, that the IHS Program Office was undercutting the Indian SUD's by going past and around them to the non-Indian health professionals at the SU's. How USET was to interact with the SU's was never appropriately defined. Their relationship was directly to the tribes, who in turn were expected to influence the SU's through the SUD's.

Future Directions

Both USET staff and the Sarasota IHS Program Office Director were aware of the need to "institutionalize" USET, recognizing that as long as the USET health component was "scotch-taped" together, utilizing individual contracts to provide USET with health personnel, the USET health component was not likely to become fully cohesive nor could it develop the image of a well-funded and staffed technical support entity to its constituent tribes. Without specific resources that could be made available to the tribes, USET's ability to impact either the IHS or the respective tribes was questionable. If USET is not used to increase the ability of the member tribes to obtain funds, USET's value to the tribes could be seriously compromised. The question is basic to USET's relationship to the tribes and to its value and validity as a mechanism.

This problem is recognized by USET staff and the USET Board, as well as by the individual tribal chairmen. USET staff have already begun to develop alternative organizational structures, and plan to broaden USET's role and to place it in a position to function as a comprehensive planner in support of the individual member tribes by building the scope and quality of its training, technical assistance and other support potential to the participating member tribes.

The basic question still to be faced is whether USET would be limited exclusively to support and technical assistance to the individual member tribes or whether the individual tribes would make a broader commitment to the potential of USET as a comprehensive planning mechanism. Whether USET would serve as an umbrella-funding mechanism, or whether the tribes are prepared to permit USET to serve merely as administrator of some components (e.g., staff training, or development of Indian health manpower), the strong commitment to preservation of individual tribal autonomy so far appears to have kept USET's role as a comprehensive health planning and support agency within extremely narrow confines.

USET offers an excellent model for affecting improvement in the quantity and quality of health services to small Indian tribes. It has the potential of being able to tailor-make its services to respond to the differing needs of the participating tribes by building a pool of centralized resources with sufficient flexibility and technical expertise to meet the unique needs of each member. In this manner, participating tribes would not have to compromise their tribal sovereignty and their own sensitivity to the needs of their tribal members in order to obtain additional resources--fiscal and technical. At the same time, by making a commitment to a centralized technical resource, the participating tribes make it possible to receive services, which it is unlikely they would be able to obtain any other way.

Whether USET will be able to realize its potential is still problematic. That it has the staff capability is clear. Whether that staff, without significant support, can avoid the many pitfalls is still to be proven. In its favor is the will to succeed and the strong interest in health exhibited by its member tribes.

II. H. CULTURAL SENSITIVITY IN IHS

A growing need is expressed by Indian tribes, Health Boards, CHR's, and IHS staff for some form of program or orientation to make the IHS medical system more culturally sensitive and responsive to the uniqueness of Indians as a distinct culture and race. The intent is to make IHS "Indian" as well as Indian-run. Making IHS more culturally sensitive should improve the manner in which patients respond to the health system and therefore help "to raise the level of Indian health to the highest level." But it should also help to make the Indian consumer feel that his health delivery system is in harmony with his view of the world and designed to serve him, rather than his having to adjust to an alien system.

1. Attitudes

Many IHS staff seemed unaware that cultural differences could significantly affect the manner in which health services are provided. When asked, most viewed delivering services to Indians as no different from serving other poverty populations. Others spoke favorably of experiences in bringing medicine men and other traditional Indian health practitioners into the IHS hospital and thought it would be beneficial to IHS to increase this practice. However, of those interviewed, too few perceived cultural sensitivity as something going beyond the use of medicine men to impact the entire shape and structure of IHS delivery system.

It was said that cultural issues get lost in the crisis atmosphere in which most SU's operate. When a doctor first comes to an SU, he is usually given a cultural orientation by the tribe, and at that point is enthusiastic about adjusting his method of practicing medicine to the values of the people he is serving. But once pressure takes over and time becomes the scarcest commodity, the cultural orientation becomes a dim memory and he concentrates on getting things done with the greatest economy of time, reverting to his medical education.

Tribal Health Board members who were interviewed were aware that the Indian perception of health was different from that of the Anglo, and that IHS was an Anglo health system, but seemed reluctant to believe that their role was to adapt the IHS system to make it more Indian. Instead, perhaps taking their cue from IHS, they saw their role as helping Indians to adapt to the IHS Anglo health system. They even questioned their right to express their concerns as Indians to IHS health professionals. IHS perception of the needs of Indian health--more doctors, more drugs--has an intimidating effect on the Health Boards, causing them to feel that their concerns about cultural factors were somehow trivial. Also, few Board members perceived that there could be a way to change IHS to become more Indian in its ways. They accepted the alternatives as being either a totally Anglo-designed IHS or no

modern health system at all. This was reinforced by IHS staff, who often responded to complaints about lack of cultural sensitivity with comments that IHS should pull out of the reservation and let the Indians go back to the medicine men for all their health needs, and let them see how they liked it.

Health Boards or other tribal health agencies, arguing for greater cultural responsiveness, find it difficult to measure the effect of harmony between Indian ways and the health system on the health of those served by it. It is much easier to measure the impact of immunization or sanitation programs. Yet, there is increasing recognition that a medical cure is affected by the patient's' confidence in the system, as much as by the physical drugs put in his body or other physiological aspects of the treatment.

Indians have always recognized that trust and faith were an integral part of any treatment. As stated by one traditional practitioner who was interviewed, "The degree of the cure may reflect the degree of trust in the methods and the relationship of trust between the patient and his medicine man." Thus it would seem that a health system alien to Indian ways, that makes no effort to adjust to those ways, would be handicapped in its ability to treat Indian patients successfully. Even in Indian health, there is a transition from acute diseases in which the patient is cured or dies, to chronic diseases, which can only be treated and controlled. This decreases the ability of modern miracle drugs to treat successfully the disease without also treating the patient, and makes the issue of how the patient responds to the delivery system even more critical.

In the final analysis, it will be up to Indian Health Boards and Indian health professionals to determine the medical effectiveness of synthesizing the best of Anglo and Indian ways. The Health Boards must decide how much of IHS resources they believe should be devoted to these priorities as opposed to competing priorities--drugs, equipment, staff, etc.--favored by the IHS staff. The Boards will have to rely on the Indian's increasing realization that the Anglo way does not have all the answers and that the Indian ways have much to contribute. However, once the decision is reached and commitment made, it should not be difficult to adapt IHS to Indian ways and to synthesize the best from the two cultures in treating Indian health problems. It is not, as some IHS staff believe, a question of all or nothing, of either accepting the Anglo medical system <u>in toto</u> or going back to the medicine man. Rather, an exciting challenge is offered--to develop a health system that is culturally attuned to Indian responses.

In all the studies of Indians, few investigations have been undertaken to determine the impact of cultural patterns on Indian perception of the institutions with which they must deal, nor how those institutions can be changed to become more culturally sensitive to the Indian. Indians must assume responsibility for defining the character of the change. Since for the near future, providers will continue to be Anglo or at least trained in Anglo health institutions, changes must be structured into the system so that they become part and parcel of it.

2. An Example: Design of Facilities

The possibilities in just one small area--facility construction--give some idea of the potential and the excitement involved in the acculturating process. Although some attempts have been made to design IHS hospitals and clinics with Indian cultural characteristics in mind, this has not been widely put in practice. An amalgamation of Indian cultural architectural concepts offers fascinating ideas of how IHS could design a hospital and clinic culturally appealing to Indians. With a small investment of effort, the architecture of IHS hospitals could increase Indian acceptance of the Western health system. But the intent in designing culturally-relevant facilities is not to camouflage an attempt to lure Indians away from their culture; rather, it is to portray Indian culture and utilize concepts that make the delivery system a balanced synthesis of the two worlds in which Indians live.

a. Location and Site

Among the most significant cultural adaptations is the location of a facility. The methods Indians utilize to locate a building or hut should be replicated. Their choice of terrain, topographical features, arroyas, hills, valleys, mountains, buttes, location of graveyards, location of water sources, etc., are all significant in determining where the Indian would most likely place a large structure. The hospital or clinic should not be located in an area that is not supposed to be settled due to clanship customs, or where Indians would never place a hut.

From this culturally determined location, the experts in engineering and architecture can (after consideration of soil borings, topography, accessibility, and economy) proceed to determine whether the location is feasible.

b. External Appearance

When Indians look at a square building sticking up like a dead tree in the middle of the desert, they find it foreboding. Yet, IHS hospital design has tended to remain substantially the same, hospital after hospital, governed by inflexible design standards and guided by architects or engineers who are not culturally attuned to Indians. According to the IHS Director, while this was true in the past, IHS is now designing hospitals with Indian input and making the design responsive to the cultural system of the tribe that will be using it. Starting from the environment, land configurations, and traditional Indian building shapes, it is possible to design a hospital and clinic that would be not only appealing, but almost Indian in origin. To achieve this the architect must be innovative, yet adhere to Indian design.

Even the external color needs to be considered. The direction of the hospital entrance is important; in many cases, the main entrance should face East, a culturally appropriate choice. The view from the side and the top should be culturally adapted, patterned after Indian symbolic designs. If the hospital complex has several buildings, the placement and interrelationship of these buildings should be harmonious. They would normally include the power plant, along with the system of roads and the patterns they create. The visual association of all these parts must be determined like a carefully woven rug, with intricate patterns that are not random, but well thought out.

c. Internal Features

To develop a culturally-conscious design, hospital or clinic planners would be expected to explore Indian concepts and attitudes. Since the hospital or clinic is an extension of the IHS delivery system at its most important level, where contact is made with Indian consumers, internal features must be acceptable to its users. If one were to take each area in a hospital, the list could be exhaustive. For the purpose of example, some ideas are suggested:

- Color schemes. Using colors most appealing to Indians (this varies by tribe), the entire wall or room appearance could become culturally appealing. This is elementary, but at times it is neglected in IHS buildings.

- Design features. Drawing from the vast body of Indian designs and symbols, selections could be incorporated into various hospital or clinic features. For instance, rounded corners are more desirable than square or sharp corners. Great heights in ceilings should be avoided Window design could be changed to provide for smaller sized windows, yet adequate in number to provide natural light, instead of massive windows with glass, which would be too revealing. Most hospitals tend to have excessively bright lights in hallways and rooms. For Indian patients, adequate lighting is still needed, but softer systems could be utilized. The location and design of the waiting rooms is particularly important, so that Indian clientele can find the room both comfortable and culturally appealing in color scheme, design representation, and type of furniture. Culturally attractive room arrangements, methods of seating, direction of seating, and distance from other areas (such as operating rooms, check-up areas, etc.) must be considered.

Indians must contribute to the building ideas and be involved in the design. No single plan or approach will be suitable for all parts of the country or even for different tribes in the same Area.

Similarly, Indian values can be applied to other aspects of health service if Indian people are invited to participate as equals, rather than merely beneficiaries of governmental largesse. If the challenge is offered to the Indian people, their perception of the sincerity of the offer can be gauged by the warmth of their response.

III. INDIANS AND IHS--
ISSUES IN THE HEALTH DELIVERY SYSTEM

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A. LEVEL OF INDIAN HEALTH

Between 1955, when the Indian Health Service took over the responsibility for providing health services to Indians, and 1971, there has been a marked improvement in the health of the Indians in the United States.

1. Morbidity

While the mortality (death) rate of the IHS service population has improved, the morbidity (disease) rates have continued to rise in every reportable classification, except tuberculosis. Indian rates are still higher than for any other group in the country in every single reported classification.

Otitis media increased 182% since 1962; strep throat 469%; and influenza 233%. Consistently, the majority of new cases occurred in children under the age of 15 (84% of otis media and 48% of influenza). Higher incidence of diseases, particularly those common to children, is due in part to the disproportionate number of children in the Indian population. (43% of rural Indians and Alaska Natives in the 24 states served by IHS are under 15, compared to 28% in the general population.)

It is difficult to compare many of the diseases that plague the Indian people with the U.S. rate since many of these diseases have almost disappeared in the general population, or cause so few cases that they are no longer considered important enough to be reported. Wherever the disease rate for the U.S. is reported the level of disease for the IHS service population is higher than that of the U.S. ranging from 4 times higher (syphilis) to 54 times higher (dysentery) among Indians. The Area Offices reporting the highest incidence of disease vary from 179 times higher than the U.S. rate for dysentary. at USET, to 9 times higher for gonorrhea at Navajo. Even the Area Offices with the lowest disease rates have higher rates than the U.S. in almost all diseases.

Cumulative rates for ten reportable diseases by Areas (Table III-A-1) show the very great difference between the Area having the highest incidence of disease--Navajo, and that having the lowest--Oklahoma. There is 6 times more disease at Navajo than in Oklahoma, yet Oklahoma runs higher disease rates in every classification than the U.S. rate except for venereal diseases.

Table III-A-1

Cumulative Rate of Ten Diseases by Area Office & IHS for the Highest and Lowest Areas: 1971

	IHS	Highest		Lowest		U. S.
		Navajo	Phoenix	Alaska	Oklahoma	
Otitis Media	10,742.4	16,401.1	16,164.1	8,159.7	4,217.2	
Strep Throat	6,453.1	11,457.4	7,793.6	3,256.1	1,399.2	222.9
Gastro Enteritis	6,060.3	11,914.2	9,226.6	420.1	1,269.3	
Pneumonia	3,002.0	5,731.4	4,927.7	1,414.1	913.6	
Gonorrhea	1,647.5	2,883.5	1,744.3	2,505.3	290.2	325.1
Trachoma	616.8	1,519.3	1,632.6	-	65.5	
Dysentery	419.0	918.1	834.2	95.3	45.9	7.3
Hepatitis	370.4	626.0	371.2	134.2	165.1	33.5
Syphilis	180.4	476.3	237.6	37.0	44.0	46.6
TB (new active)	157.4	176.7	387.2	200.3	52.8	17.0
Total	29,759.3	52,104.0	43,319.1	16,222.1	8,462.8	
Ratio IHS/Area Office		1.75	1.46	.55	.28	

Source: IHS unpublished data

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Almost three in every ten Indians and at Navajo more than one in every two Indians have had one of these major reportable diseases during 1971. Improvement in incidence of morbidity (see Table III-A-2) for IHS is recorded for only two diseases from 1968 to 1971. The same kind of intensive effort is needed to bring these other major diseases under control that has been invested in controlling trachoma and bacillary dysentery.

Overutilization of the outpatient services was a theme that was repeated by both IHS staff and Indians throughout the country. Overutilization of some clinics by some patients undoubtedly occurs, as is true for any clinic or doctor's office anywhere. But the need to use the outpatient services seems well-documented by the high level of disease on the reservations; and the fact that the morbidity rate continues to climb is probably due to greater utilization of the clinics, better reporting and better diagnosis, rather than the fact that Indians have more illnesses than they had in the past. Nonetheless, the evidence of continuing and rising levels of serious disease suggests that any prognosis that there will be a reduction in the use of health services by the Indian people is totally unjustified (see Table III-A-3).

Rather, the shocking, continuing rise in otitis media and strep throat diseases that are now controllable in the remainder of the population indicates that the rising morbidity rate demands more extensive and responsive clinic services to Indians. Even without causing death, the debilitating effects of the diseases prevalent among the Indians (deafness due to otitis media, blindness due to trachoma, and life-long disabilities due to the excessively high accident rates) leave a substantial handicap and seriously affect their lives and their eventual employability. For these reasons, the outpatient clinic rather than the inpatient hospital has become the key service component of the IHS health delivery system.

2. Mortality

Unlike the incidence of disease, the death rate among Indians has improved over the past 19 years since IHS has taken over operation of the health care system for Indians. 1/

1/ However, the IHS mortality data are reported on the entire Indian population in the 24 states in which IHS provides service to Indians, rather than only on those Indians in the IHS service area. Thus, there are major questions in interpreting the mortality date reported by IHS as to how accurately they reflect the health status of Indians in the IHS service area.

Table III-A-2

IMPROVEMENT IN MORBIDITY*
1968 - 1971

	I H S	ABERDEEN	ALBUQUERQUE	ALASKA	BILLINGS	NAVAJO	OKLAHOMA CITY	PHOENIX	PORTLAND	TOTAL
Otitis Media			I		I		I			3
Gastroenteritis			I	I	I		I		I	5
Strep Throat				I			I			2
Pneumonia	I		I	I		I	I		I	5
Gonorrhea										0
Trachoma	I	I	I			I	I	I	I	6
Dysentery		I		I			I		I	4
Hepatitis		I								1
Syphilis							I		I	2
Tuberculosis		I			I		I		I	4
T O T A L	2	4	4	4	3	2	8	1	6	32

I = Improvement
*Source: IHS-unpublished data
Data on USET & Tucson not available

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Table III-A-3

Incidence Rates for Leading Notifiable Diseases Among Indians and Alaska Natives in IHS Service Areas

1962 - 1971

Rate per 100,000 Population

	1962	1971	% Increase (1962-1971)
Otitis Media	3,801.7	10,724.2	182%
Strep Throat, Scarlet Fever	1,132.4	6,443.0	469%
Gastroenteritis	4,545.5	6,050.1	33%
Influenza	1,025.6	3,418.1	233%
Pneumonia	2,867.3	2,997.0	5%
Gonococcal Infection	756.8	1,644.7	117%
Trachoma	930.4	615.8	-34%
Bacillary Dysentery	637.5	415.3	-35%

Source: IHS computer data, 1971

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Life expectancy was 60.0 years for Indians in 1950; it was 64.9 in 1970, as against 71 years for whites nationwide. The reduction has been greater in certain specific causes of death; 86% decrease on deaths from tuberculosis; 84% from gastritis; and 57% from influenza and pneumonia. Indians have had a rise in accident death rate (16%), cirrhosis (174%), and diabetes (40%) since 1955.

Proportionally, the age-adjusted Indian death rate is still 40% higher than the U.S. death rate. Suicide is 1.9 times higher, homicide 3.1 times higher. Death due to alcoholism is 9.0 times higher than the rate for the U.S. Accidents were the leading cause of death among Indians each year from 1955 through 1971, with rates 3.3 times those of the nation as a whole. Cirrhosis of the liver, the fourth leading cause of death among Indians (after heart disease and cancer, both age related) rose 221% during this time period, from 14.2 deaths per 100,000 in 1955 to 45.6 deaths per 100,000 in 1971. Tuberculosis and gastritis are still running higher than for the nation as a whole, though less than in 1955. Among the areas, the highest death rate is in Portland. Navajo, which has the highest morbidity rate, had the lowest death rate in 1966, and Phoenix, with the second highest morbidity rate, had the lowest rate in 1971.

3. Maternal and Infant Death Rates

The death rate for Indian infants is 23.5 per 1,000 live births compared to 19.2 for the total population and 16.8 for whites. This rate is 62% lower than it was in 1955, compared to a 27% reduction for both whites and non-whites during the same period. Neonatal death rates for Indians are similar to those for whites and one-third lower than for non-whites, but post-neonatal death rates for Indian babies are 2.9 times as high as for whites and 19% higher than for non-whites.

The birth rate of Indians per 1,000 population in 1971 dropped since 1955, but it was still 1.9 times the U.S. rate and 2.8 times as high in Alaska. The fertility rate for Indian women was 2.4 times higher than the U.S. rate--while the maternal death rate was 1.9 times higher than the U.S. rate.

III. B. IHS HEALTH DELIVERY SYSTEM

IHS's mission is "to assure the availability of a comprehensive health service delivery system..." 1/ IHS provides an extermely broad range of health services, from surgical proceedings to building privies--probably the broadest range of services offered by any health deliverer in the country. Services include the traditional inpatient hospital care, outpatient clinic services, dental, pharmacy and mental health, plus a wide range of field and preventive programs including sanitation and environmental health, public health nursing, well-child clinics, family planning, mental health, nutrition, pre- and post-natal care, school health, and a variety of immunization programs. The range of services has expanded rapidly over the past few years as IHS moved away from just the provison of basic medical services into outreach and preventive programs. In addition to the IHS program on the reservation there are other health programs, varying from SU to SU, that may be affiliated with IHS, or be funded to the tribes.

1. Facilities

IHS facilities are provided through 51 hospitals ranging in size from 6 to 259 beds (including three regional medical centers at Anchorage, Gallup, and Phoenix) all of which have both inpatient and outpatient clinics, plus 83 health centers--outpatient instllations with one or more full-time physicians (operating independently of a hospital)--and over 300 health stations and field locations (installations with part- or full-time staff without a full-time physician). This includes medical services in a number of BIA boarding schools. Hospitals represent the most significant facilities utilized by IHS. A 1957 study of IHS concluded that, "The obsolescence of Indian hospitals is so dangerous as to threaten most seriously the provision of an adequate quality of medical care in the Indian health program." 2/ Since 1955, the IHS has built 13 new hospitals and made major alterations in a number of others. IHS has built 17 health centers and 58 field stations as part of its increasing field health service.

However, IHS still has 19 hospitals that need to be replaced, and 14 that need major modernization at a projected cost of $200 million. Of the 51 hospitals, 35 are not in compliance with federal fire and safety codes. 3/ Only 21 of the hospitals are accredited by the Joint Commission on Accreditation of Hospitals. 4/

1/ IHS Mission Statement.

2/ 1957 Study of Indian Health Service, Surgeon General's Report.

3/ Unpublished IHS data.

4/ Ibid.

However, the number of patients using inpatient health care in IHS hospitals has decreased over the last ten years. Patients are spending fewer days in the hospital for each illness, because although major diseases still are rampant on reservations the illnesses are not as severe as they were,and more chronic than acute diseases are being treated. Also,changing medical practice now encourages hospitals to send patients home as soon as medically possible. Most major medical procedures are now done either in regional medical centers or in contract care hospitals. As a result, many of the IHS hospitals are underutilized. The average utilization for IHS direct care hospitals, excluding regional medical centers, was 49% in 1973. 1/ (That is,only 49% of the hospital beds were being used by patients on an average day.) The utilization of the regional medical centers is much higher, though still below the national average: 63% at Anchorage, 76% at Gallup, and a very high 83% at Phoenix in 1973.

2. Patient Utilization of Facilities and Clinics

In 1973, Indians had an inpatient admission rate to IHS and contract facilities of 218.2 per 1,000, up from 206 in 1970. In 1973, each Indian averaged 4.77 visits a year to IHS and contract care outpatient facilities. (This included all field visits to homes, immunizations in schools, and other IHS field contacts, in addition to visits to the outpatient clinic.)

In comparison, for the United States as a whole, the inpatient admission rate was 145 in 1967. Outpatient visit rates are much more difficult to obtain for the general population since individual doctors and other providers are more scattered and have much less sophisticated reporting systems than does IHS. In general, it is estimated that the average American makes between 4 and 5 outpatient visits a year.

However, comparing IHS to average United States data is not really useful in an effort to answer a question raised by many IHS staff; whether Indians overutilize the IHS facilities, particularly the outpatient care. The average U.S. figures are for a population which has a higher level of health and which does not have the availability of the outreach programs IHS provides for Indians. The closest population found to use as a comparison was a Medicaid population being served by an HMO under an OEO grant. This is a low income population with a higher incidence of disease than the general population. Also, HMO's attempt to provide preventive care and, since there is no charge to the patient, the similarities to the utilization situation of IHS facilities were relatively good.

1/ Compared to a national utilization of 83% in 1968.

Generally, it was found that after a person became a member of the HMO, his hospital utilization went down, but his use of outpatient visits went up. Inpatient care for the Medicaid population under study went from 172 hospital admissions per 1,000 enrollees to 95 admissions per 1,000 enrolles over a three year period. Outpatient services went from 3.64 visits per enrollee per year to 3.85 visits per enrollee per year. However, the sample population utilized in the HMO study had no children under one year old or persons over 65 years old, the two groups in the population with the highest hospital utilization rate. In IHS children under one account for 10.4% of the inpatient visits and 6.2% of the outpatient visits. Reducing the IHS utilization figures by these percentages the comparable IHS utilization rates come to 176 hospital admissions per 1,000 enrollees per year and 3.24 outpatient visits per enrollee per year. Indian outpatient utilization is therefore lower than for a comparable poverty population. When their excessively high incidence of disease, higher than for any other population in the country, is weighed into the formula, it appears that on a comparative basis, Indians are, if anything, still underutilizing the outpatient clinics.

3. Hospital Utilization

All IHS hospitals are underutilized but the amount of underutilization varies from Area to Area.1/Maintaining hospitals that are not adequately utilized is expensive, first in maintaining a staff for the hospital, and second by spending more per patient in contract care hospitals than if the patient were served in IHS hospitals. Hospitals can be maintained at or near capacity, particularly those as well-equipped and staffed as the IHS Medical Center in Phoenix and Anchorage. Fewer hospitals that are better utilized could relieve some of the pressure on the contract care money which would permit those Areas with few or no other resources to take advantage of the contract care funds.

1/ In order to determine the degree of underutilization, the percent of all IHS population, the bed capacity, the ADPL (average daily patient load) for IHS hospitals, the ADPL for contract care, and the patients in all hospitals (contract and IHS) are divided by their incidence in each Area (see Table III-B-1). Lowest utilization of hospital beds in any Area was in Aberdeen and the highest was in Navajo. On the other hand, Aberdeen received a high proportion of all the contract care funds. Phoenix has a comparatively high utilization of its IHS facilities, but also has a large portion of the contract care money in relation to its population, providing Phoenix with more hospital services in comparison to its population than other Areas. Portland has no IHS facilities and receives a large proportion of the contract care funds, but not enough to make up for it lack of IHS facilities compared to other Areas that have both sources of hospital funding. Alaska receives 6% more hospital and contract than its proportion of the IHS population.

Table III-B-1

Population Bed Capacity and Hospital Utilization
IHS and Contract Care Hospitals

		1970				1973			
	% of Service Population	% Bed Capacity	% ADPL* IHS	% ADPL Contract Care	% of All Hospital	% Bed Capacity	% ADPL IHS	% ADPL Contract Care	% of All Hospital
Aberdeen	14%	17%	14%	23%	16%	18%	15%	13%	15%
Alaska	11	23	20	8	18	19	19	13	17
Albuquerque	7	7	7	6	7	6	5	8	6
Billings	6	3	3	21	6	3	3	13	6
Navajo	20	20	25	5	21	21	25	10	21
Oklahoma	23	14	14	9	13	13	11	10	11
Phoenix	11	13	16	10	15	16	17	15	16
Portland	5	-	-	17	3	-	-	14	4
USET	2	-	-	-	-	2	2	3	2
Tucson	2	2	1	-	1	2	2	1	2

Source: IHS 1970 and 1973 unpublished data.

* ADPL means average daily patient load.

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4. Staffing Utilization

There are approximately 7,506 persons employed by IHS. This includes 486 doctors, 180 dentists, 1,100 registered nurses, technologists, ambulance drivers, sanitarians, etc. IHS also makes extensive use of paramedical persons such as physician's assistants (Community Health Medics), midwives, mental health aides and others. While there is no universally agreed upon proper ratio of providers to patients, by almost any measure IHS is greatly understaffed.

IHS, in its testimony before Congress, presented the following statistics on current IHS ratio of health professionals to population compared to the ratio generally recommended throughout the country:

Table III-B-2

Ratio of IHS Health Professionals to Service Population vs. Recommended Ratio

	Current Ratio	Recommended Ratio
Physicians	1/938	1/700
Dentists	1/2,800	1/1,650
Otolaryngologists	1/120,000	1/20,000
Audiologists	1/480,000	1/30,000
Ophthalmologists	1/54,200	1/12,000
Optometrists	1/69,714	1/10,000
Pharmacists	22/100,000	65/100,000
Social Service Workers	1/7,283	5/10,000
Registered Nurses	207/100,000	458/100,000
Public Health Nurses	29/100,000	40/100,000

The staff shortage goes beyond professionals to other support staff. The Veterans Administration standard for outpatient staff is 2.2 staff for each 1,000 persons; IHS has only 0.6 to 1,000 outpatients. For inpatient care, a similar pattern appears; the United States standard is 3 staff to 1 patient. IHS has 2 staff to 1 patient.

Looking at it another way, in 1973 only 30% of all IHS hospitals met even 80% of their staffing standards. Only 14% of all outpatient clinics in hospitals met even 80% of standard staffing levels and 33% met less than 40% of the standard staffing level. One of the reasons for this latter figure is that in many hospital clinics nurses are assigned to the inpatient service, but are asked to help out in clinic, and are then frequently called away from the clinic by inpatient needs, leaving the clinic bottlenecked. Fifty percent of the health centers meet at least 80% of their standard staffing needs and none fall below 40%.

One of IHS's most severe problems is its shortage of aides and assistants. While many tribal leaders have been asking for more doctors and dentists, an increase in the number of paramedics would also improve the quality and quantity of care in IHS, while costing less, and providing jobs for Indian people. Studies show that a ten percent increase in the number of patients served by a doctor can be achieved by increasing the number of traditional aides per physician from 2 to 2 1/2.

In addition, an expansion in the number of physician's assistants, nurse practitioners, and dental auxiliaries offer even greater potential for productivity increases than do traditional aides. One dentist with 4 assistants can serve the same number as 2 dentists with 3 assistants. If a physician is given a physician's assistant or community health medic, it will increase his productivity between 30% and 70%.

Paraprofessionals working outside the clinic or hospital have also been able to reduce the workload on doctors. One IHS experiment, using just CHR's and IHS field health staff (no doctors), not only decreased the mortality rate for one infant disease to zero, but reduced inpatient admissions for that disease by 49% and clinic usage for it by 25%. 1/

Given this kind of evidence coupled with the doctor shortage, increased employment opportunities for Indians, and lower costs, tribes and Health Boards might consider asking IHS Health Educators to deal with the staff shortage through the increased utilization of Indian paraprofessionals rather than health professionals. However, this brings up again the problem of position slots. So long as the government holds IHS to a fixed number of slots, it will not have the flexibility to take advantage of its paraprofessional utilization (see the discussion on position slots in the Budget Section).

1/ HPSC Infant gastroenteritis program conducted at the Sells Service Unit.

III. C. HEALTH BENEFIT PACKAGE

IHS likes to describe itself as an Indian HMO, a local comprehensive health resource for which Indians paid with their land several generations ago. 1/ The comparison points up a major problem in the IHS delivery system. An HMO establishes a contractual relationship with its subscribers to provide a clearly defined package of health services. If the HMO refuses to provide a particular procedure included under the contract, the subscriber can sue the organization for breach of contract. However, the IHS health services do not offer a specified package guaranteed available to all Indians whenever they need care. IHS provides many different kinds of services, but not to every Indian in every Service Unit, when he needs it. Some services are available on one reservation, but not on another. For example, only 52% of all SU's provide professional health education services and only 33% offer full-time mental health services. 2/ Also, within a particular SU certain services may only be available to some of the people who need them. The limitation on the contract care funds requires IHS to offer specialists only to those most seriously in need of surgical procedures while those who are not in that category cannot get them. Only 26% of those in need of otitis media surgical procedures in 1973 received them. 3/ When a doctor has to see 60 or 80 clinic patients a day, it is questionable whether he can be providing complete outpatient services to his patients. Many Indian consumers complained that their clinic experiences left them with the feeling that some of their medical problems had not been addressed. The result is that the Indian consumer is not being provided a comprehensive care program by IHS.

In part, this situation exists because IHS is only funded at 70% of need. However, shortage of funds is not the only reason. The IHS budget has quadrupled in the last five years without improving the right to services of individual consumers. IHS has used much of this increased budget to expand into new areas of health services, tackling a wide range of serious health problems, but treating fewer Indians than all of those needing services. This arrangement, throwing available resources to the areas of greatest immediate need, has saved numerous lives and headed off many potential health crises. There is no evidence that IHS has not made the best use of its limited funds.

The problem with this approach, however, is that it places

1/ See Section on Health Maintenance Organizations for a more detailed comparison between HMO's and IHS.

2/ IHS 1973 Forward Plan.

3/ IHS 1974 Forward Plan.

the Indian health consumer in the position of a health supplicant. He is given no legal basis on which to demand services. When he goes into an IHS facility, he has a right only to that which he is given; and what he is given is frequently a function of how much work a doctor can squeeze into 24 hours, how much money the SUD can squeeze out of a limited contract care budget, as well as a function of how much money the AO, Headquarters and Congress have decided to allocate the particular medical problem affecting the individual Indian consumer. Under these circumstances, it is misleading to tell an Indian consumer that he is being offered a comprehensive health program. The comprehensiveness of IHS lies in its variety of offerings, not in its availability to any individual consumer. This situation effectively eliminates Indian rights for IHS services, and its effects pervade the IHS system. Indians report that when disagreements arise between provider and patient, the providers become indignant when a patient makes a demand, particularly when the provider feels that he has extended himself beyond what he is required to do. Indians sense the "Lady Bountiful" approach (with IHS offering and Indians expected to be duly grateful), and Indians resent it. This results in antagonisms between consumer and provider, often overtly expressed during our interviews as well as in many other consumer surveys and hearings. This antagonism is not unusual when parties are giving and receiving <u>favors</u>, rather than giving and receiving <u>rights</u>.

Also, lacking a defined health care package, it is difficult to hold IHS accountable. Several IHS staff persons felt that the agency was trying to please everyone. It has continually assumed new priority areas set by IHS or by Health Boards, but without making the essential corresponding decision as to what should be deemphasized. As a result, resources are spread more and more thinly. With twice as much work as they can possibly handle, doctors end up doing all of their tasks in only half the time they should be devoting to them. IHS's goal becomes one of trying to do as much as it can within existing resources, a goal that is impossible to pin down. When an individual Indian or Health Board complains to IHS about its failure to provide a service or about its inadequacies in a particular area, IHS's reply is that it is trying as hard as it can, but it has only limited resources.

There is little question but that IHS is trying as hard as it can and is attempting to plug the big holes in the Indian's health situation. But under the present system, an individual will never have a right to a specified service, and an Indian Health Board will never be able to define IHS's responsiblity, until IHS is funded for 100% of need (an unlikely occurrence), and until some effort is made to predetermine a health care package that is guaranteed to <u>all</u> Indians.

A major challenge to this situation is now underway. A lawsuit was recently filed against IHS and HEW on behalf of a

Navajo child who was denied an otitis media operation because IHS did not have sufficient funds in its contract care budget. 1/ The suit asserts that federal laws and IHS regulations give her a right to the operation because Congressional intent was not to make the benefit contingent on the existence of available resources but to provide a benefit to which every Indian in need is entitled. If successful, the lawsuit would establish for the first time the legal right of an Indian consumer to IHS health services and could persuade HEW and Congress to increase IHS funding to enable Indians to exercise these rights. If successful, presumably other lawsuits will follow covering other services. This means that IHS, in order to protect itself from never ending legal action will have to confront the question of its undefined benefit package.

Whether or not the lawsuit is successful, the question of the benefit package is one that IHS and the Indian Health Boards should consider in an effort to change the health system from a charity program to one that gives Indians specific rights and guarantees specific services. The question is whether in seeking new funding, IHS and Indians should seek funding for more bits and pieces of programs, or instead seek funds to guarantee that an Indian has an entitlement to specific services, rather than just a vague entitlement to IHS. IHS and Indians could begin developing a program-benefit package, a list of services agreed to by both, to which an Indian would have a right whenever the need was demonstrated. A joint effort would be needed to convey to Congress the need to provide IHS with adequate funds to meet 100% of need for the particular benefits agreed upon. 2/

Such an agreement should be designed to avoid conflict with the right of local Health Boards to set priorities that are responsive to the needs and wishes of their particular communities. One way to do this would be to use an approach employed by HMO's; the development of both a basic package and a supplemental package. The basic package could be developed by the Area and national Indian Boards to cover generally agreed-upon basic procedures that are an Indian's entitlement while the supplemental package would be developed locally and be responsive to local needs.

1/ Dale v. Weinberger, United States District Court, District of New Mexico, filed November 1, 1973.

2/ A possible way to accomplish this in accompaniment with the introduction of National Health Insurance is outlined in the Section on National Health Insurance.

III. D. THE OUTPATIENT CLINIC

Indian Health Service outpatient service is the dominant point of contention between IHS consumers and providers. The outpatient clinics consume more of the providers' time than any other aspect of IHS health delivery. Most consumers have their primary contact with IHS here, and it is from this contact that the consumers' judgment of IHS is primarily drawn. The clinics are the source of most complaints by both providers and consumers, coloring the consumers' feelings towards the providers and vice versa.

Indian consumers interviewed for this study and as recorded in numerous other studies 1/ cite the same grievances again and again. They complain that they must travel long distances, frequently at considerable expense, and then must wait many hours in the clinic to be treated. Once served, they are rushed through the system as if on an assembly line, with little or no attention paid to their personal concerns. Underlying these complaints is the feeling that they are forced to undergo a dehumanizing experience, in which they are not viewed as individuals with individual illnesses and problems.

Providers, particularly doctors, also raised the outpatient clinic issue as their number one source of dissatisfaction. Forced to practice medicine that they feel will have little long-range effect on improving the status of Indian health, the doctors saw the clinic as only a "revolving door." They agreed that Indian consumers were not treated with due deference to their individual needs, and expressed unhappiness about this. But IHS providers also maintained that the reverse was also true; that Indians viewed them as machines to provide medical treatment, rather than as human beings, which in turn tended to color their attitude towards Indians and increase the distance between the two groups.

Clinic Utilization

Outpatient usage of IHS clinics has increased five-fold between 1955 and 1973. IHS staff views on the significance of the increase differ. Some see it as a positive sign, that the message that IHS has been trying to get across to Indians over the past 19 years--come to the clinic when you first begin to have a medical problem, don't wait until the problem becomes acute--is having its intended impact, and that present increased utilization of clinics should eventually pay off in a decreased work load for IHS staff and better health for the Indians.

Others in IHS see negative implications in the heavy usage of clinics, feeling that IHS has oversold its program and now Indians are coming in for treatment for minor or even spurious problems. According to this view, having gotten "hooked" on IHS, Indians now

1/ Hearing, Commission on Civil Rights; NIHB Consumer Evaluation Study.

must be educated on the proper use, as against the "abuse," of medical services. Also, the fact that the services are free is seen as creating a problem; "The price you pay for free medicine is that people will see a doctor rather than a pharmacist for a minor cold."

However, comparison of IHS outpatient utilization data with similar data from HMO's and from various consumer health surveys indicates that Indians are not using outpatient services at any greater rate than the rest of the country. Both Indians and the general population see a doctor between four and five times per year. Given the higher level of disease among Indians, a more valid conclusion could be that, while some individual Indians may be overutilizing outpatient services, the Indian population in general is probably still underutilizing them.

If the problems in the IHS clinics do not result from Indian overutilization, they do result, at least in part, from shortages of resources. Staff indicated that a shortage of support staff (particularly nurses) and of waiting room space is at least as great a problem as the shortage of doctors. However, since the IHS budget has quadrupled over the last five years, resources have been available but apparently were not directed to the needs of the clinic in adequate amounts.

1. Decrease in Clinic Utilization vs. Improved Treatment of Consumers.

During the interviews it became clear that one of the reasons for the lack of resources devoted to clinic-needs, and for the continuing problem between Indians and IHS over the clinic, is that Indians and IHS approach the clinic problem from very different perspectives. IHS seems to feel that putting more resources into the clinic will not have a significant "medical" impact. Money put into preventive and other programs will do much more to improve the level of health on the reservation. Therefore their approach is to try to contain the clinic problem without additional resources until the preventive programs decrease the load on the clinics. Containment includes such measures as trying to decrease utilization and improving the routing of patients through the clinics.

From the Indian perspective, the primary focus is not overload, but rather how to improve the way they are treated in the clinic setting. Reduction of caseload may be one way to improve the consumer-provider relationship, but it is not the only way, nor is it inevitable that reducing the load will accomplish the goal of better treatment. Improved treatment in the clinic setting is important, if Indians are not going to be reluctant to come in during earlier stages of illness. But, according to the Indians interviewed, even that does not deal with the basic issue. They want to be treated as human beings in the clinics. This is as important a factor, in their estimation, as quality health care or other IHS priorities.

Of the IHS staff interviewed, only one Service Unit fully accepted improved treatment of consumers as a valid priority for its own sake, to be given equal weight with the provision of specific medical programs, i.e. good human relations as an end in itself. At Papago, the Tribal Executive health staff and the SUD agreed to make improved treatment of consumers in the clinics the number one SU priority, and took affirmative steps to implement it. The SUD told our interviewers that he had come to realize during a serious illness that the preeminent importance given to "quality" of medical care was nonsense and that the relationship between the provider and the consumer was at least as important (and perhaps more so) in how a consumer responds to medical care. With the shift in Indian health from acute diseases that can be cured to chronic diseases that can only be treated and kept under control, the doctor-patient relationship becomes even more significant in the success of medical treatment.

Implementation of these goals at the Papago clinic did not involve any all-encompassing solution, but rather the institution of numerous small steps. The amount of clinic space was doubled through the purchase of some trailers, and the space gained was used for additional examining rooms. Previously, nurses assigned to the hospital were loaned out to the clinic on an "as available" basis during clinic hours, thereby leaving gaps and creating bottlenecks in the clinics when nurses were called back to hospital duty. These nurses were transferred to the field health section primarily to serve in the clinics, helping out in the hospitals only when they were free. The SUD found this afforded no decrease in the level of hospital care, since operations could be scheduled and most of their other hospital duties were as high priority as tasks in the clinic. The SUD also attempted to deal with some of the doctors' complaints, to assure their more ready response in the clinic. One doctor was taken off the day clinic and officially assigned to the evening shift. In that way, the doctors who worked under pressure during the day were not called during the evening to deal with minor medical problems brought into the emergency clinic by Indians who could not get off work or secure transportation during the day.

While it is too early to determine the results in the Papago clinic from these steps, their approach does establish two important principles. First, improved treatment of consumers in an IHS clinic is a legitimate priority to which increased resources can be devoted, even if it means withdrawing resources from "medical" programs. Second, if a community decides that improved treatment of consumers by the system has a higher priority for them than a specific medical program, a strong tribal Health Board can exert this objective.

Another method being used to improve provider-consumer relationships under IHS is to assign each consumer to a particular physician, so that when the consumer comes to the clinic he sees the same doctor each time and develops an ongoing relationship with him. While this technique was being used on several reservations visited, one of the most far-reaching successful programs

seen was the community physician program on the White Mountain Apache Reservation. The reservation is divided into defined communities. Each doctor is assigned to a community and serves all health consumers from that community. The doctors' outpatient schedules are adjusted, so that a consumer has an 80% chance of finding his community's doctor on duty during any clinic hour at the single main clinic. In addition, the doctor makes regular visits to the community to get to know it and to make house calls. Gradually, field health staff and CHR's are also assigned to specific communities. With the doctor, these workers form a community health team.

Once the doctor gets to know a patient, he will need less time to familiarize himself with the case history, thereby making more time available to spend with the patient. This is in contrast to the system used at other SU's visited, i.e. having a patient see a different doctor, not only for each different problem, but for different visits for the same problem--a time-consuming process, that becomes even more dysfunctional as the prevailing Indian diseases shift from acute to chronic.

A survey taken six months after the system was implemented found that almost the entire reservation population was familiar with the program and the vast majority were very happy with it. The doctors too were pleased, because they could develop relationships with patients, feel a part of the community and offer better health service. On being told of the White Mountain program, a physician at another SU, commented that he would enjoy seeing the same patients regularly and that the opportunity to develop relatively normal, on-going relationships with his patients would be a definite incentive to stay on beyond his two-year hitch.

In another effort to deal with the clinic problem, HPSC has developed a computer program whereby use of an outpatient simulator computer enables an SU to identify bottlenecks in the clinic.

IHS is also experimenting with ways to use the schools as a major health resource. Of the total IHS outpatient caseload, 35% are under the age of 15, many of them in school. By training teachers and school health nurses to identify symptoms, treat minor problems, and refer serious ones to the clinic, IHS hopes to be able to catch children's ailments in the very early stages. By treating as many problems as possible in the school itself, IHS can cut down on the time school children lose waiting in the clinic and reduce the time the clinic spends on minor problems.

2. <u>The Doctor Shortage</u>.

The range of solutions available to IHS to deal with the problems in the outpatient clinic will, to a large degree, depend on how it resolves its existing doctor shortage. When Congress ended the military draft in 1972, one of the by-products was the end of the doctor draft, the primary means by which IHS obtained

its physicians, dentists, and certain other professionals. Many people in IHS consider their new task--finding doctors to voluntarily serve on reservations--the most serious threat to the continuation of direct health services by IHS, since IHS must now join the competition for doctors willing to work in a rural area.

There is some disagreement within IHS as to how serious this problem is. Some Area Directors say they have had no trouble filling their slots and do not foresee any trouble in the future. Others predict that certain reservations--those with nearby recreation facilities or those with a certain mystique among the American public--will have no trouble attracting doctors, but that reservations in poor climates without glamour will be seriously hurt. Some at IHS believe that the only solution will be the training of paramedicals at the SU's to treat minor problems themselves and maintain a patient with serious ailments until he can be transferred to an urban or regional medical center where doctors would be available. The costs would be met out of various third party funds such as Medicare, Medicaid, health insurance, or IHS contract care. Others feel that IHS hospitals should become community hospitals, and IHS should contract for doctor services. They feel that having one rural doctor serve both Indians and non-Indians would utilize more efficiently the limited number of rural professionals available.

Presently IHS has filled 151 of the 196 physician vacancies that will open up in June 1974, when the first turnover of doctors after the end of the draft will occur. IHS is using a three-pronged approach to the doctor shortage: 1) increasing the use of paraprofessionals, 2) developing new methods for recruiting doctors, and 3) encouraging doctors to remain beyond their initial two year contract.

HPSC is working on programs to expand the use of paraprofessionals. Rather than training paraprofessionals to assist doctors, they are looking at the functions a doctor performs and contend that they can assign out almost 80% of all physician tasks to other health workers. Some of HPSC's pilot projects on the Papago Reservation substantiate their progress in this area.

IHS is engaging in a number of new activities to recruit and retain physicians. It is sending letters to all graduating medical students and internists throughout the country, encouraging them to join the IHS program. It is trying to make the Service more financially and professionally attractive. The Bonus Pay Act that recently passed Congress authorizes IHS to raise physicians' salaries. It is attempting to assure that all physicians receive all the benefits to which they are entitled as members of the Commission Corps. A provision of the Jackson Bill S. 2938, would provide funds to enable doctors to receive periodic training and refresher courses during the course of their service on the reservation.

The National Service Corps and an HEW program called COSTEP pay for part of a doctor's medical education in return for a commitment to serve on a reservation for a certain period. The

Jackson Bill would provide funds to significantly expand this program.

IHS is also making a concerted effort to encourage doctors to extend their period of service with IHS. According to most IHS doctors we interviewed, staying with IHS depended less upon money and training than on the quality of their experience. In deciding whether or not to extend their original two-year hitch, they are influenced by the same factors most likely to affect doctors considering entering IHS: the quality of the work experience and the attitude of the Indian people. They suggested that these factors offer the best opportunity for IHS to improve its retention rate, requiring neither additional funds nor resources. The issue raised by doctors more frequently than pay or physical working conditions was their feeling of lack of recognition, by either IHS, the tribes, or the individual consumers, for the job they were doing. They felt that no one appreciated the efforts they were making.

They felt the Area Offices paid little attention to them and barely acknowledged their existence or rewarded them with a pat on the back for their day-to-day work, the doctors said. The only exception was for an outstanding doctor, whom the Area would recognize and shower with attention. There was also a feeling that the doctor's role has been downgraded in IHS because of the increased attention paid to community development and other non-medical programs.

In contrast, the doctors interviewed who were continuing on after their two-year hitch were all staying with IHS for personal reasons, e.g. they had initiated a project for which they had responsibility and for which they felt a personal investment.

The predominant attitude among doctors towards the tribes was summed up in the comment, "The tribes appreciate you even less than IHS does." These physicians objected to the dehumanizing atmosphere in the clinics. They feel the tribal governments are not interested in health and are frustrated because the tribes do not respond to their efforts to seek input from tribal leaders or Health Board members. Where there was an active tribal Health Board, the doctors indicated strongly that the Board's involvement was a positive factor in their work situation. It gave them a feeling that the tribe was concerned with the issues that affected them and appreciated the work that they were doing.

In addition,doctors complained about lack of social integration into the Indian communities in which they were working. They were not invited to Indian homes, and their social life was centered almost completely around the IHS compound. IHS is aware of the issue but places full responsibility on the Indians and talks of the need for tribes to make the doctors feel more wanted and more at home in the community. However, many Indians who were interviewed resented the lectures that they were receiving from IHS to the effect that they had to fawn over their doctors at the risk of losing them. They felt that this was demeaning, and that IHS was

putting itself in a role as apologist for Indians. They felt that any increased social integration between doctors and tribal members had to come through a mutually initiated process.

From our interviews it seemed that neither the Indians nor the doctors were unwilling to improve the relationship; however, neither side felt it was its responsibility to take the first step. Rather than lecturing tribes, IHS should take the initiative by initiating dialogues with tribal leaders on the issue. It should also take a look at its own system to see what IHS attitudes and practices, such as building isolated housing compounds, contribute to the problem. This area also presents a critical role for tribal Health Boards. They should begin discussing the barriers perceived by the Indian community in order to better relations with the doctors. It appears that the necessary effort to recruit and retain doctors will be successful only if IHS takes the first step and both Indians and IHS participate as equals.

III. E. ALCOHOLISM

During the course of the interviews, alcoholism was identified as one of the major sources of conflict between IHS and Indians--second only to the problems in the outpatient clinic. It causes conflicts between IHS doctors and patients in the clinics and hospitals, and between IHS administrators and Health Board members at the Board meetings. In neither case is the situation being dealt with rationally and sympathetically--particularly given the magnitude of the problem.

1. The Dimension of the Problem

Alcoholism is a problem of enormous dimensions for Indians. Interrelating with other problems of social disorganization, it results in violence, arrests, auto accidents, broken homes, lost jobs, and wasting of human lives and human potential. In addition to the social devastation, alcoholism causes or contributes to an array of physical disabilities that must be treated by IHS, and thus drains the medical care resources available to address other health problems. A Billings Area analysis shows that the initial diagnosis of 10% of all IHS hospital admissions indicated direct alcohol involvement (acute intoxication, habitual and episodic excessive drinking, and alcoholic psychosis). 1/ A Phoenix Indian Medical Center (PIMC) study found that 50% of deaths between the ages of 5 and 70 at PIMC were alcohol-related. 2/ Approximately 40% of all patients registering in the emergency room of the Alaska Native Medical Center were there due to problems associated with alcohol use. 3/ The combined category "Accidents, poisonings and violence" appeared as the second leading cause of hospitalization in IHS and its contract care facilities in 1972. 4/ Accidents were the leading cause of death among Indians, and cirrhosis of the liver the fourth leading cause.

Indian Health Boards have recognized this enormous drain on Indians and have consistently given the alcohol problem a leading priority. When the eight SU Health Boards in the Billings Area were asked to list their major health problems by priority, five listed alcoholism as number one, and one listed it as number two.

1/ Report to AIHB

2/ Interview with PIMC mental health staff

3/ Alaska Native Health Board. "Evaluation of Alcoholism Treatment Services in the State of Alaska." A report.

4/ Data supplied by IHS

2. IHS Approach to the Problem

Given the tremendous problems caused by alcoholism for both Indians and IHS, and the emphasis given it by the Health Boards, IHS's activity on alcoholism in the SU's and Area Offices visited was remarkable by its absence, Portland being the most notable exception. IHS has no separate budget item for alcoholism and related problems, nor are data being systematically collected on the dimensions of the problem or on the validity of various experimental approaches. For example, the White Mountain Apache Tribe legalized liquor on the reservation several years ago, an issue many tribes are wrestling with; IHS has made no study to determine the effects of legalization on alcohol-related problems. 1/

There seem to be several reasons why IHS is doing so little in this area, despite the magnitude of the problem. The reason given by IHS is that the responsibility for dealing with alcoholism was taken away from them by Congress and assigned to the tribal alcoholism programs that are funded by the National Institute for Alcohol Abuse and Alcoholism, (HEW). Because of this IHS is not given a separate budget or the manpower to deal with alcoholism.

However, the picture one gets in the field is somewhat different. Some Areas, particularly Portland, and some SU's, are actively involved in the problem and are engaged in some exciting and innovative projects. In other places there was neither interest nor activity in the field of alcoholism treatment, and the underequipped tribal programs were bearing almost the full responsibility for the problem. Alcoholism appears to be another situation in which IHS was avoiding accountability in a difficult problem area by providing services where it felt so-inclined, and where it did not, ignoring the problem completely on the grounds that it did not have the resources or responsibility.

There also seemed to be several other factors that contributed to IHS's lack of action on the major problem. One is a "holier than thou" attitude that exists on alcoholism among some IHS staff; that alcoholism is a dirty, messy problem that is the Indians' "fault" and, therefore, not IHS's responsibility. This attitude is reflected in a report prepared by an IHS Area staff, responding to a recommendation by an AIHB on reducing or eliminating the alcoholism problem, using existing resources during FY 74:

1/ UAI attempted to use morbidity and mortality data to draw conclusions from the experiment. No firm conclusions could be drawn from the limited data available, but certain interesting, though inconclusive, results were obtained, which suggest that IHS should investigate the subject further.

"People who drink a lot will continue to come to us with medical complications of drinking. They have a right to services for their bona fide physical disabilities, even though self-induced. This is often unpleasant for us, but it is nevertheless true. If they want to continue injuring themselves, there is indeed very little we can do about it. Except we can avoid worsening the situation: we can avoid fighting with these patients and forbear from discourtesy; we can establish rules for services that we expect all patients to follow (such as for the night use of the emergency room); we can avoid dishonesty and be clear that the "cure" of any drug addiction (including alcohol) is entirely voluntary. It is no small matter to follow the Hippocratic principle, "Above all, do no harm." We would do harm to pretend that health is not a joint responsibility. We do our part, and if the patient chooses not to do his, that is his responsibility."

In contrast is the attitude expressed by an Indian Health Board on the same matter, a quote from the evaluation of IHS alcoholism treatment by the Alaska Native (Area) Health Board:

"Any individual with a health problem has a right to expect that the care provider will perform responsibly and in an organized fashion. It is well known that many different medications are available to treat a variety of illnesses. Any patient expects their physician to find out what is wrong before giving a medicine. He also expects his doctor to make sure it is working and if it is not, to change it to one that does work. The alcoholic or problem drinker has a right to these same standards of care. The Alaska Native Health Board is currently prepared to attempt implementation of a program to improve the care system for the alcoholic or problem drinker." 1/

A related attitude, expressed by some staff, was that IHS should stay away from controversial issues such as alcoholism, which brings out strong feelings on all sides--that IHS should not get involved, even as a technical resource, in discussions of such issues as the legalization of alcohol or the problem of off-reservation bars.

1/ Alaska Native Health Board, op. cit.

However, a number of IHS staff indicated that they were concerned and wanted to do something about the problem, but were frustrated because they did not know how to attack it. The causes of alcoholism are primarily social, they felt, and, short of changing the socio-economic situation on the reservations, IHS staff maintain that there is little they can do to impact the problem. IHS has provided them with no working models around which to build a program. Given the absence of proven methods for treating alcoholism, others felt that any accomplishments would be small for the effort and resources invested; such a commitment would waste IHS's limited resources; and the same resources could accomplish more if applied to other programs in which clear methods of treatment existed and immediate and visible results could be produced.

Alcohol is indeed a sensitive problem, alcoholics are difficult persons to treat, and no one treatment method produces guaranteed results. Still, there are several problems with the ostrich-like attitude towards alcoholism IHS is presently taking. IHS asks the Health Boards to list health priorities in an absolute sense, rather than relative to specific dollar investment or possible accomplishments. When the Boards list alcoholism first, IHS concludes that, while alcoholism may be important, it is a bad investment relative to other uses of resources, and is therefore inclined to ignore the recommendation. This produces an extremely negative side effect on Indian involvement in health. Given all the facts, the Boards might have reached the same conclusion as IHS, but they also might have decided that alcoholism is so serious a problem that it justifies the reallocation of resources, even given the risks involved. There is no way of knowing what a Board's decision would be until the Board is provided with alternatives and enough information on which to make a reasoned judgement. In the meantime, IHS places its own interpretation of what the Boards would conclude, an interpretation that coincides with IHS's own reluctance to involve itself in the alcohol issue. The result is to make Indian Health Boards justifiably suspicious of IHS intentions and sincerity in offering the Boards the right to establish their own priorities.

3. Treatment Methods

While there is no one sure cure for alcoholism or problem-drinking, a variety of treatment methods have been developed, each effective with at least some of the patients who have used it. Some of these efforts could be used by IHS as models in attempting to solve the alcohol problem.

A successful alcoholism program at the Chemewa Indian School involves the students in its development and implementation. The Portland Area involves traditional medicine practitioners in alcoholism programs.

HPSC is developing an approach to alcoholism that uses the same methodology it has applied to other diseases: classifying the different kinds of alcoholics and the different levels of severity of the disease, and then trying to determine which methods of treatment work best for different kinds of alcoholics at different levels of the disease. They than identify who should perform different aspects of the treatment process at different times. This approach, which puts alcoholism into a manageable perspective, would allow a SUD to spell out to a Health Board enough facts about the possible alternative programs so that the Board could make a considered judgement in assigning its priority to alcoholism.

Alcoholism in common with certain other diseases is a social problem, whose cause and control are vitally affected by what is happening in the community. This aspect has not been an insuperable barrier to IHS's effectiveness in its treatment of other diseases. When it was determined that the cause and treatment of gastroenteritis was affected by poor sanitary facilities in Indian homes, IHS became involved in the construction of sanitation facilities. The demands of the Health Boards place on IHS the obligation to become actively involved in developing a position on alcoholism and its side-effects ,such as accidents, homicide, etc., and to explain its rationale for inclusion or exclusion to the Health Boards.

IHS could start by developing materials describing all successful or partially successful approaches to alcoholism. This material should be disseminated to its own staff and to the Indian Health Boards, including a study of cost factors for each. At every SU data on all suicides, homicides, influenza, pneumonia, etc. and accidents (both automobile and those in the home and at work) should be reported on the basis of whether they are alcohol-related in order to develop the data on the true severity of alcohol as a medically-related problem. A study should be undertaken of all successful or partially successful approaches to alcoholism that could be adapted to Indians, and the results disseminated both to SU's and to the IHB's. Where tribal Health Boards, after being given all the facts, still identify alcoholism as a priority, IHS should assign staff to work with and support the tribal alcoholism program. IHS should select several of the most encouraging approaches to treating alcoholism and operate demonstration and/or research projects in cooperation with the tribes at several SU's. The National Safety

Council should be requested to participate in developing approaches to solving the problem of the increasingly high accident rate on reservations. Based on the results of the completed HPSC study, IHS should mount several demonstrations to make the study operational, and should utilize the results of the various approaches to keep the Health Boards fully informed as to the results.

III. F. CONTRACT CARE SERVICES

The Contract Health Services (CHS) program (also known as contract care) is the second major part of the IHS health delivery system. The primary function of CHS is to purchase medical services that IHS hospitals and clinics do not have the staff, equipment, or facilities to provide. It also pays for emergency procedures, such as auto accidents, where the Indian victim is rushed to a non-IHS facility, as well as for drugs or medical devices that IHS cannot supply directly to its patients.

On some reservations served by IHS there are no IHS direct care facilities at all. In those places, CHS is used as a complete substitute for IHS hospitals and clinics. IHS staff authorizes the use of CHS funds and monitors the care purchased. For example, all of the inpatient care and 44% of the outpatient care in the Portland Area is provided by non-IHS providers and paid for out of CHS funds.

On the other hand, the Phoenix and Navajo Areas have large Indian medical centers with staff specialists and the capability of performing more complex operating procedures. Thus, the SU's in those Areas have less need to purchase services outside of IHS. The actual mix between direct care and CHS varies from SU to SU, and from AO to AO.

A person is eligible for contract care services if he is eligible for other IHS services. However, since there is a limited amount of money available for contract care, priorities are set, both in terms of who the person is, and what his medical problem is. First priority goes to emergency services and to essential medical services. Roughly, these are provided where life and death are at stake. Next priority is elective medical care service--services to treat a problem that may leave the patient with an impairment if not treated, but will not bring on rapid death (such as a middle-ear operation on an otitis media patient).

The categories are by no means clear-cut and their application raises some extremely difficult problems. It requires making decisions, in effect, about who lives or dies and who shall be healed and who not. IHS uses the example of the choice between spending $25,000 on a kidney transplant to save one life, or spending the same amount of money on 20 otitis media operations, so that 20 children will not go through life with hearing impairments. Primary responsibility for making priority decisions on CHS rests at the SU level, usually in the hands of the chief medical officer. (If the SU's contract care budget is inadequate to pay for a particular procedure, the SU may seek additional funds from the AO, in which case the AD and the Area CHS officer will also participate in the decision.) IHS is trying to develop better techniques for making priority decisions but, recognizing that there will always be some human judgment involved, the SU also involves Health Boards in the process.

1. Funding

CHS is a separate line item in the IHS budget. CHS funds are allocated to the Areas. Each SU is given a rough CHS budget figure as a prediction of the amount it will be able to spend in the coming period for contract care. However, it is difficult to tell in advance what an SU's CHS needs will be. A serious auto accident or major operation can use up an SU's entire allotment. Therefore, the Area Office retains the prerogative of responding to one SU's emergency by taking funds from another SU's CHS allotment.

Because of this, an SU during the first half or three-quarters of the fiscal year will tend to use its contract care funds for emergency and urgent procedures, but will hold back on its elective surgery and develop a file on these needs. As the end of the fiscal year approaches and the SU has a better sense of how much contract care money remains, staff will begin to take care of the procedures in their elective surgery file. How far they can go down their list depends on how much money is available. Those on the list who are not served become the "contract care backlog."

IHS now purchases most of its contract health care on an individual fee-for-service basis. (It pays a doctor a fee for each patient he sees or each procedure he performs.) The 1973 HMO Act gives IHS the authority to purchase services on a prepayment basis. IHS may now enter into an agreement with a provider in which a flat annual or monthly fee is paid the provider and, in return, the provider promises to provide all needed services to certain designated Indians (e.g. all those living in a part of a reservation that is far from the IHS clinic but near a private provider). This authority provides IHS with an additional tool in shaping its CHR program, though it is still too soon to determine how IHS will use it or what impact it will have.

The contract care backlog is obviously a major problem for IHS. IHS simply does not have the money to pay for all the surgery and other medical procedures that are needed but can be provided only through the CHS program. The Aberdeen Area estimates that it has 20,000 persons who are without needed medical procedures because of the lack of sufficient CHS funds. Billings estimated its backlog at about 10,000 persons.

The IHS budget has increased about five-fold since 1956. The amount allocated to CHS has increased at an even faster rate. (In 1956 CHS accounted for 22% of the IHS budget; it now accounts for 27%.) Despite this increase, IHS is now able to buy only half the number of procedures through contract care that it could in 1956. The budget increase has been eaten up by the spiraling cost of medical care.

The cost of medical care is probably going to continue to increase. At the same time, IHS will have an increased need to purchase care through CHS, since medical procedures increasingly are performed by specialists whom IHS cannot afford to employ on its staff on a full-time basis. A continuation of HEW's personnel freeze on the size of the IHS staff decreases the capacity of the

direct care program so that more services must be purchased on the private market. If the doctor shortage hits IHS with the impact some expect, there will be even less direct care services and the use of contract care will have to be increased further.

These factors indicate an increased strain on the CHS budget in the future. However, this situation may become manageable, if the Jackson Indian Health Bill passes. It proposes that the government spend $123,500,000 over the next five years to eliminate the contract care backlog. More third party money is becoming available, which can pay for services now paid for out of CHS funds. For example, on the Flathead Reservation, which has no direct care services and is served completely by CHS, Medicaid, and Medicare, private health insurance and other third party resources pay for about 20-30% of all medical costs. When a National Health Insurance program is enacted, an even larger proportion of the procedures now paid for out of CHS will be paid for by third party sources.

2. Specific Issues for Tribal Health Programs in Contract Health Services

While the contract care backlog is the most immediate problem for the CHS program, there are several other important issues which tribal health programs can impact significantly which may be harder to deal with than the money issue.

a. Monitoring

Under the CHS system, IHS is responsible for monitoring the quality of care given its patients by contract care providers and facilities. At the SU's, IHS doctors review the discharge summary for each CHS treatment to evaluate the adequacy and necessity of the treatment. If they suspect that a particular facility or provider is giving poor quality treatment, they notify the Area Office, which sends a team out to review the charts and to talk to the provider or facility administrator. HEW is also promoting the development of Professional Standards Review Organizations (PSRO's) to monitor the quality of care provided under Medicaid and other federal programs. IHS said it would consider contracting with PSRO's to review care provided under CHS. However, the PSRO concept has met with tremendous opposition from the medical profession--and it may be years before the federal government has the capability to adequately monitor the quality of medical care. Until then, IHS will have to rely on the imperfect system of chart reviews and complaints by consumers.

In the Areas visited there seemed to be no organized concerted effort to monitor discriminatory practices reported in the contract care program. Nor is there any systematic program to orient contract care providers to the cultural differences and needs of their Indian patients. In some Areas, informal procedures were used; a Public Health Nurse would stop in to talk with the administrator

of a contract care facility, or the CHR's would be asked to report complaints to the SU. In other Areas the staff did not seem conscious of the issue nor did they perceive it as a problem.

Throughout IHS there was a feeling that the agency is not in a good position to monitor and enjoin discriminatory practices. Staff felt that there was a basic conflict between IHS's role as a purchaser of medical care and its role as an advocate for Indians. In many IHS locations IHS needed the CHS providers more than the providers needed IHS. The staff indicated that most rural doctors and facilities have so much demand for their service that they would not miss the IHS contract care money. Yet these providers and facilities are often the only ones available in the Area. IHS staff noted that if they pursued complaints against CHS providers, it would ruin IHS's relationship with them and make it very difficult for them to obtain needed contract care services. Staff considered their main responsibility to be insuring the availability of contract care services. In their opinion someone else should address the problem of discrimination against Indian patients.

IHS staff mentioned the Office for Civil Rights (OCR) in HEW as the agency that is in the best position to do the monitoring. OCR is responsible for insuring non-discrimination in all HEW-funded programs and has the authority to terminate a provider's Medicare and Medicaid contracts. Such a course of action would have much greater financial impact on a provider than would the termination of his IHS contract. However, OCR has a small staff and is located in the ten HEW regional offices, which makes it difficult for it to reach out to remote reservation areas. IHS has no formal system for gathering complaints from its patients and relaying them to the regional OCR offices. On the other hand, IHS feels that OCR has not responded aggressively when complaints are filed by Indians. The end result is almost no activity to prevent or stop the discriminatory practices in contract care facilities that Indians continue to complain about in the various public forums.

On those reservations where discrimination and lack of cultural sensitivity by contract care providers and facilities continues to be a problem, Indian tribal health programs are in a position to do something about the inaction of IHS and OCR on this problem. Tribal programs are better able to eliminate discrimination and cultural insensitivity and are closer to the community to serve as a clearinghouse for complaints and case histories. Since they do not have to negotiate medical contracts with the contract care providers, they are not caught in the conflict IHS feels. Also they may be more successful in getting OCR to take action, particularly if they work through the OCR Indian Advisory Task Force. In addition to bringing complaints, tribal programs could also engage in educational programs to prevent such practices. Many tribal programs already provide orientation programs for IHS doctors. Such programs could be expanded to include contract care providers. Since IHS feels it is not in a position to adequately perform its responsibilities in this area, tribal programs could

consider asking IHS to contract with them for the monitoring of discrimination in contract care facilities.

b. Employment

As a greater percentage of medical care is provided through CHS and outside of the IHS direct care program, more of the jobs, particularly the support and paraprofessional jobs, will move from IHS to the private sector. This means that employment in IHS will not increase in proportion to any increase in the IHS budget, and thus there will be fewer job opportunities for Indians in IHS. Significant further action will be necessary to insure that Indians get their share of jobs in contract care facilities.

Under Executive Order 11246 and Title VI of the 1964 Civil Rights Act, contract care facilities are required to take affirmative action to employ minorities, and IHS and OCR have the responsibility for monitoring their employment practices. HEW is also in the process of developing regulations to require the preferential employment of Indians by all parties having contracts with HEW on or near reservations. Despite these legal requirements IHS seems to be making little systematic effort to insure that Indians are given an opportunity for employment at contract care facilities. Most of the contract officers interviewed did not see this as a major issue in which they should be involved. They also raised the problem of their conflicting roles--that it is difficult for them to push for Indian employment and still maintain the necessary amicable relations with contract care facilities.

The proposed HEW regulations give a tribe the right to take over the role of monitoring employment practices of contracting parties. Tribes could contract with IHS to monitor employment practices of contract care facilities. Given the high unemployment rates on the reservations, tribes can ill afford to lose employment opportunities for their members as IHS makes increasing use of contract care facilities. This appears to be a problem area where tribal health programs could undertake to fill the vacuum left by IHS inaction.

c. Tribal Control

Another problem with the contract care program is that it is not open to tribal involvement and control. While SU Health Boards or tribal health departments can influence the IHS direct care program to make it more responsive to Indian needs, there is no mechanism presently available that allows them to exercise similar control over CHS.

In a few Areas, Indians have obtained positions on the Boards of the local CHS but tribal participation in monitoring employment and service to Indians in CHS facilities does not provide enough Indian involvement to insure that the Indian voice is heard in those facilities. Unless the service purchased with one-fourth of the IHS budget is going to come under the control of the tribal

health programs, it will be necessary for NIHB, the tribal Boards, and IHS to develop new mechanisms for guaranteeing tribal input into CHS services.

d. Termination.

A number of IHS and tribal officials interviewed indicated that they were afraid that contract care was becoming a subtle form of termination of IHS. Whether consciously or unconsciously, under the pressures of HEW personnel freezes and health manpower shortages, they felt that IHS would gradually increase the proportion of care being provided through CHS, until health care for Indians is integrated into the health care system for the rest of the population.

The enormous CHS case backlogs make it clear that more funds are needed for the CHS program. The increase in the CHS budget must not, however, come at the expense of the direct care program or as a subtle form of termination. The NIHB, Area Boards, and tribal health programs are being given an increasing opportunity to participate in the IHS budget-making process. Indians should be conscious of the termination danger inherent in the CHS program and should use their authority to counteract some of its dangers.

Conclusions

If, as indicated above, contract care means discriminatory and culturally insensitive care, lessened employment opportunities for Indians and loss of burgeoning tribal control over health care, then expansion of contract care wipes out most of the major components of the special relationship between Indians and the federal government. There seemed to be very little sensitivity among the IHS field staff as to the potentially detrimental effects of contract care. It appears that a conscious policy to protect against the dangers inherent in the CHS program is needed, if IHS is not going to drift into them. The policy needs to be developed by IHS and Indians, and could have two prongs. First, the kinds of joint IHS-Indian programs discussed above could be developed to increase the safeguards protecting the special relationship; such programs could include IHB monitoring of employment and patient discrimination, increased tribal control over the program and a watchful eye on the CHS budget allocations.

A second approach that needs to be examined is the development of alternatives to the expanded utilization of contract care. The Phoenix, Gallup, and Anchorage Indian Medical Centers provide many of the services to their Areas that other Areas purchase through CHS. With a regional Indian medical center the problems of employment, cultural sensitivity, and Indian control become far less complicated. IHS is also trying to expand the practice of bringing specialists to the IHS hospital, rather than sending the patient to a contract care facility. The 1973 HMO Act which gives IHS the authority to enter into prepaid and fixed fee contracts, could also provide an alternative to CHS, and possibly provide IHS with a greater degree of control over the services it purchases.

III. G. THIRD PARTY RESOURCES

Third party resources are resources for the direct provision of health services, or funds that can directly pay for health services. Examples of resources for the direct provision of health services are tribal alcoholism programs, county hospitals, and Veterans Administration hospitals for Indian veterans. Programs which finance health services include Medicare and Medicaid, Workmen's Compensation, and private insurance purchased for Indian employees of private companies. This second group of resources is generally referred to as "Third party payors."

The variety of third party resources has been expanding rapidly over the past few years, offering new health resources to both Indian consumers and to IHS. For example, an Indian enrolled in Medicare or Medicaid now has a choice: he or she can go to an IHS clinic, or instead can go to the nearest private physician who will bill Medicare or Medicaid for most or all of the cost of the visit. For IHS, this means that instead of using its limited contract care funds to pay for surgery in a private hospital, it can utilize a patient's Medicare or Medicaid benefits to pay for the service or can ask him to use the nearest V.A. hospital.

Third party resources have important implications for the future of health services to Indians. However, to insure that full benefit is obtained from these resources there is a continuing need to inform Indian consumers about their rights to such programs and to monitor the state and federal agencies administering such programs to insure they respect Indian rights to such benefits. Secondly, the fact that agencies which provide health resources to the rest of the country are also serving Indians poses certain challenges to the special relationship of Indians and IHS. The special relationship needs to be redefined to include these new health resources, and also needs to be reaffirmed to make sure that these new resources do not lead to the gradual erosion of the IHS program.

The implications of third party resources on Indian health are somewhat different for the IHS contract care program than for the direct care program. They are discussed below.

1. Application to IHS Contract Care

The most immediate impact of third party funds is that they permit IHS to stretch its contract care budget considerably further. Such resources as Medicare, Medicaid, private or government employee health insurance, V.A., county hospitals, Vocational Rehabilitation, the Crippled Children's program, and Workmen's Compensation all provide services or pay for services for eligible Indians that IHS has traditionally paid for out of its CHS budget. If an Indian chooses to use his/her third party resources, IHS can then use the contract care money to serve a patient who is not covered by a third party program.

Presently,third party resources account for only 2% to 3% of the money spent on Indian health. The Billings Area Office estimated that between 20% and 30% of IHS consumers in the Area are eligible for some kind of third party coverage, and throughout IHS there is a major effort being made to help Indians identify all third party resources available to them, to assist them to become eligible, and to make it easy for them to use these resources. For example, in a pilot project on the Wind River Reservation, the SU is reviewing every patient's file to determine what alternative resources are available to each consumer.

Access to Third Party Resources

Because Indians are citizens and IHS is a residual service, none of the third party programs may legally deny services to an Indian on the grounds that he is covered by IHS. However, certain programs have been reluctant to grant Indians their full rights. In particular, programs that are administered by state and local governments, which have traditionally discriminated against Indians, have attempted to deny Indians access to their services. Many state Medicaid programs and county hospitals have erected barriers to prevent Indians from using their third party resources.

a. Medicaid

Medicaid is funded jointly by the state and federal governments. Many states have been reluctant to spend money on Indian health services and have avoided doing so by not informing them of their eligibility. (The State of Arizona had refused until this year to implement a Medicaid program at all because it did not want to serve Indians.) IHS has been making efforts to correct this problem. IHS, the Office for Civil Rights, and the Health Services Administration (which administers Medicaid in HEW) have drawn up a memorandum of understanding on Indians and Medicaid. It states,

> "No recipient of federal financial assistance (i.e., a state or county or city government) may, therefore, refuse to certify as eligible or fail to provide health services to Indians on the ground that Indian Health Services are available." 1/

The memorandum goes on to say that HEW will require all state Medicaid programs to take affirmative steps to locate eligible Indians, inform them of their rights to Medicaid, and enroll them in the program. The memorandum also applies to other HEW state programs such as Vocational Rehabilitation, which has also resisted serving eligible Indians. While the memo was drafted in the fall of 1973, it still has not been issued by HEW. It is still unclear

1/ Memorandum of Agreement--Provision of Medical Services to Indians.

when it will be issued or what steps HEW will take to insure that it is carried out. Following up on this memorandum could be another task for tribal health organizations.

b. County Hospitals

Most county hospitals have an obligation to serve indigent persons without cost, either under their charters or under Hill-Burton regulations. However, certain county hospitals, particularly those in urban areas, refuse to serve indigent Indians seeking medical services, informing them that IHS is the Indians' primary health resource and referring them back to the nearest IHS facility, perhaps hundreds of miles away. HEW's Office for Civil Rights, responding to charges made by Phoenix Indian residents to the U.S. Commission on Civil Rights, recently filed a charge of discrimination against Maricopa County Hospital because of the hospital's refusal to treat indigent urban Indians. The Department of Justice has filed a similar charge against the Anadarko Municipal Hospital in Oklahoma. It appears that only as Indians continue to raise complaints and government agencies continue to bring charges will state and local governments come to accept the right of Indians to be served by these third party programs There is a need for Health Boards to establish a system for receiving complaints from Indian consumers and then forwarding the complaints to the relevant enforcement agency.

2. Premiums, Deductions and the Special Relationship

Third party resources also introduce such factors as premiums and deductibles, factors which have not been issues for Indians under the existing contract care system.

For an Indian who is enrolled in Medicare to be entitled to service for medical (as opposed to hospital) coverage, he is required to pay a monthly premium ($7.20) for Supplementary Medical Insurance. For both medical and hospital benefits, he must also pay a portion of the actual cost of the medical services he receives, i.e., the deductible requires him to pay the first $60 plus a 20% copayment of the private medical care received, before Medicare picks up the rest of the costs. Many private insurance policies work the same way. Many of the National Health Insurance proposals also require the consumer to pay premiums and/or deductibles. These third party programs raise issues for the special relationship that Indian health organizations and IHS are going to have to discuss and resolve. For example, should IHS or tribes encourage their members to enroll in these kinds of programs and if so, who should pay for the premiums and deductibles.

The Medicare program is a good example of the problems raised by third party programs that have premium and deductible costs attached to them. When an Indian uses his Medicare or other resources instead of making IHS tap its contract care funds, IHS will usually pay the deductible out of its contract care budget. However, the agency argues that it cannot pay the monthly premiums

for Supplementary Medical Insurance (SMI) based on an opinion by the General Counsel of HEW that IHS can only pay for services actually rendered. 1/ If it pays a premium for a Medicare eligible, there is no way of knowing that he will actually use his Medicare benefits over the course of the year. As a result, IHS is paying for a possible service, not an actual service.

IHS and SSA have been actively encouraging Indians to enroll in SMI. While this is clearly to the benefit of IHS, it is questionable whether it is beneficial to the Indians. An Indian is entitled to free direct care from IHS and to free contract care, if he needs services that are encompassed by IHS's priorities at his Service Unit. Therefore, except for those circumstances when services needed by a consumer are outside the scope of the IHS benefit package for IHS funding capability, the only reason for an Indian to enroll in SMI is to underwrite the IHS contract care budget. It is questionable whether an aged Indian should be encouraged to spend $7.20 a month out of his small Social Security check to subsidize the IHS program. In fact it does not appear that even IHS gets much benefit out of it. A study of several counties in Arizona, California and Oklahoma shows a very low utilization rate of Medicare SMI by Indians. 2/ In fact they sometimes pay as much as five times more in premiums than they receive back in benefits. The IHS policy of encouraging Indians to enroll in SMI should be closely analyzed by IHS and Indian health organizations and Boards. Tribal health groups might want to begin educating their members about these programs and the pro's and con's of enrolling in them.

The Medicare situation also raises the question, in light of the special relationship, as to whether Indians, who use IHS services almost exclusively, should ever be asked to pay premiums for third party resources. If the government is required to provide free comprehensive health care to Indians, should an Indian be encouraged by IHS to pay a premium, or should this be an obligation of IHS or Congress? If the federal government gave adequate funding to IHS, it would not be as important to seek alternative sources of funds. If the IHS or tribes picked up these costs, at least they would be spread equitably among all Indians served by IHS. Since many of the proposals for National Health Insurance consist of insurance packages for which the consumer pays the premium, this question will become increasingly important in the future. It is essential for the Indian community and IHS to determine the obligations of each on the question of Medicare enrollment and payment of premiums, so that IHS can enlarge the scope of the resources available to its program, and Indians can preserve their special relationship with the federal government on health.

1/ Since IHS is specifically permitted to cover the costs of prepayment under the HMO Act, it is possible that the General Counsel will extend this to payment of premiums under Medicare.

2/ Urban Associates, Inc. Phase I Final Report, 1973. See charts in the appendix. The only exception is Dewey County, Oklahoma.

Apparently the concept of IHS as a residual resource is now producing substantial tangible benefits for Indians. Increased availability of third party resources means more health service options for Indians and more resources to supplement IHS's CHS budget. However, the greater utilization of third party resources also means the increased dispersal of health services to Indians into the private health sector, which raises the same issue raised by the increased utilization of contract care: how to keep the growing availability of private sector services, vis-a-vis direct IHS care, from eroding the special relationship between the federal government and Indians for health services. IHS reports that some Indians are refusing to use third party resources, even if they do not require the payment of a premium, because they are afraid that it will lead to the termination of IHS services. The challenge to Indian groups and IHS is to develop an approach that enables them to use the expanded resources from third party programs while preserving the special right to IHS services. This problem has been raised most often lately in regard to the advent of National Health Insurance which, if implemented, would represent the most comprehensive third party resource. Some possible approaches for resolving the dilemma between expanded resources and protecting the special relationship are developed in the section on National Health Insurance. These approaches are also applicable to other third party programs and should be read in conjunction with this section.

3. Third Party Resources and the IHS Direct Care Program

Presently third party resources have no impact on the IHS direct care program. Third party programs cover many of the services IHS provides in its clinics, hospitals, and field health programs. IHS is not permitted to be reimbursed when it provides covered services to Indians enrolled in such programs. The Medicare statute provides that "No payment may be made under this part to any federal provider of services" (42 USA 1395(d)). Medicaid has a similar provision in its regulations. Most insurance policies, including the ones offered to federal and other employees and those purchased privately, have similar provisions. Therefore the underfunded IHS direct care program is receiving no direct benefits from the increasing flow of third party resources available to Indians.

This situation is inequitable and penalizes Indians for having a special health relationship with the federal government. The federal government tells Indians that they cannot use their third party benefits at IHS because the federal government is responsible for IHS and is funding it directly. It then funds IHS at an inadequate level, assuring IHS that the health services available to Indians are much worse than those available to citizens who use their third party resources in the private health sector.

The situation is even more inequitable, since Indians contribute directly to third party programs through taxes (the Medicare payroll tax) or by payroll deductions to cover the cost of

premiums for health insurance. They pay into the program but are denied a realistic opportunity to use the benefits they are paying for, and end up subsidizing the third party programs. As indicated above, data show that Indians on reservations pay as much as five times more in Medicare premiums than they receive in benefits. Insurance companies are making a windfall profit off Indians since Indians pay the full rate and have little opportunity to utilize the benefits.

It might be argued that since it is all federal money coming out of one big federal pot, it makes no difference what the name of the program is. If Congress wanted to raise the amount of funds available to IHS, it could do so directly by increasing IHS's budget, rather than indirectly through Medicare, Medicaid, or other programs. However, if IHS is prohibited from obtaining reimbursement from these third party programs, Indians are blocked from tapping the increasingly large flow of federal money becoming available to fund direct health services to the general population. Instead, they must wait until HEW, OMB, and Congress turn their attention to Indian health and must be content with whatever increases those agencies decide to trickle into the IHS direct care program. There is no expectation that this trickle will be equal to the share Indians would have been entitled to out of the larger flow going to all citizens. Thus, the special relationship between Indians and the federal government could have the net effect of making Indians second-class health care citizens.

There is now legislation before Congress to correct this inequity. The Jackson Indian Health Bill (S. 2938) would make IHS eligible for reimbursement from Medicare and Medicaid when it serves an Indian consumer who is covered by one of those programs. Legislation needs to be introduced to do the same for other health programs and from government and private insurance companies. This issue is particularly important with National Health Insurance looming on the horizon. It is therefore important for Indian health organizations to develop a firm position on the right of Indians and IHS to reimbursement from third party programs, to establish it now for existing programs, and then to carry it through to National Health Insurance. This issue and some options for approaching it are discussed in the section on National Health Insurance.

III. H. NATIONAL HEALTH INSURANCE

National Health Insurance (NHI) promises to be the largest health program ever adopted in this country. The impetus for NHI is a growing recognition that this country has a responsibility to insure that every American can obtain quality health care regardless of income. Since no NHI legislation has been passed, there is no single definition of what NHI is. The central idea is that the Congress should pass some form of legislation to insure that income is not an obstacle to obtaining quality health care.

At least a dozen different approaches for instituting NHI have been developed and introduced in Congress. The different approaches vary in a number of respects. In some, the federal government would play the primary role; in others private insurance companies would play the lead role. Some plans would pay for a broad range of health services, while others would only pay for catastrophic illness after the consumer had spent a given amount of his own money on health care. Some plans provide for voluntary participation; others provide mandatory participation. The amount of premiums, deductibles and coinsurance a consumer would have to pay himself also varies widely from plan to plan. None of the plans would establish a federal health delivery system; in all of them private providers and hospitals would continue to provide the health services just as they do now.

Whichever proposal is adopted, it will significantly change the health care financing system in this country and will feed billions of new dollars--federal and private--into the health care system.

NHI has had a high priority with the Administration and the Congress. President Nixon made it a major feature of his 1974 domestic program package. Congress has already begun to hold hearings on certain Bills. There seems to be a general consensus in the government that some form of NHI will be adopted within the next two years.

1. Relationship to IHS and Indian Health

From the perspective of Indian health, NHI can be viewed much like other third party resources, such as Medicaid, Medicare, or private health insurance; except for one overwhelming difference. Because of its size and scope, NHI will reshape the entire federal role and responsibility in the health care area, including the federal relationship to Indians on health. As a result, the issues which have slowly been emerging with respect to Indians

and third party resources, and which up to now have been relatively minor issues for Indian health, will become major issues under NHI.

The Section on Contract Health Services discussed the threat to Indian self-determination in health created by the rapid expansion of IHS contract care services. The Section on Third Party Resources raised the danger that such resources pose for the continuation of the special relationship and of IHS as direct care delivery system. The Section also examined third party resources as potential sources of increased dollars for IHS services--in amounts unlikely to be obtainable through the standard IHS appropriations process. These three issues--the threat to self-determination, the danger to the IHS direct delivery system, and the potential of substantial new health monies for Indians--will all become pressing issues when NHI is adopted.

Some Indian spokesmen have perceived NHI solely as a danger, and have advocated that Indians be excluded from the program. 1/ However, NHI offers Indians potential benefits as well as pitfalls. The challenge to the Indian community is to develop an Indian approach on all NHI proposals that maximizes the benefits and avoids the pitfalls. In the opinion of several Congressional staff persons working on NHI, Congress would listen sympathetically to an Indian position on NHI, suggesting ways for Indians to expand their entitlements both as Indians and as citizens. The danger lies in NHI being adopted without such an Indian input. Past experience indicates that when general legislation aimed at the total population is adopted without consideration to Indian needs through Indian input, the special needs of Indians are not properly considered. As a result, Indians are often hurt by unintended side-effects of that legislation. The tendency of Indians to perceive only entitlement programs as programs on which Indians should take a position has done them a great disservice.

2. Specific National Health Insurance Proposals

Of the dozen or so plans for NHI that have been proposed, four were selected for analysis in this report: the Health Security Bill, the Long-Ribicoff Bill, the Administration Bill, and the Kennedy-Mills Bill. These were chosen because they are the major Bills presently under consideration and because they represent in many ways the broad spectrum of approaches that have been developed to implement NHI. This analysis is not intended to be comprehensive, but rather to deal with the issues that affect Indians.

1/ Presentations made by tribal representatives at the Conference on Indian Health, sponsored by Senator James Abourezk, Feb. 7, 1974.

a. The National Health Security Plan

Description

"The National Health Security Plan" is the most comprehensive of the proposals. A "cradle to grave" plan, it would cover almost the entire range of personal health care services, including a number of preventive care programs. Everyone living in the United States would automatically be covered. The Plan would be administered by a Federal Health Security Administration, which would reimburse providers directly from a special trust fund, 50% of which would come from a special payroll tax on employers (3.5%) and employees (1%) and 50% from general federal revenues. There would be no premiums, deductibles, or copayments 1/; that is, the consumer would have no out-of-pocket expenses when he sought medical services.

In addition to paying for health services, the Plan proposes various mechanisms to control the cost and quality of care and promote a more rational system of health planning and health services. The Plan would subsume and thereby abolish Medicare, Medicaid, and a number of other existing federal health programs. The cost is estimated at between 60 and 80 billion dollars a year, but the amount of new money it would add to health programs would be much smaller, because most of the above figure would be in replacement of the billions of dollars already being spent by the government and the private sector on health care.

Impact on Indian Health

The Health Security Bill would cover almost all of the services IHS now pays for through contract care, and thus would pay for care for almost all Indians who have had to forego treatment because of IHS's limited contract care budget. If IHS could obtain reimbursement, the Plan would also provide coverage for most of the services now provided by IHS through its direct service program. It would not cover sanitation, environmental health, Indian community development, and a few other services presently provided by IHS.

1/ Out-of-pocket expenses in insurance policies include deductibles and copayment (or coinsurance). Deductibles are out-of-pocket expenses a consumer must pay before the insurance pays anything. Copayments are the amount the consumer has to pay at the same time the insurance is contributing, after the consumer has paid all the necessary deductible amounts. Thus if there was a $150 deductible and a 20% copayment on a $500 bill, the consumer would pay $150 plus $70 (20% of $350) while the insurance would pay $270 ($350 minus $70).

However, as presently drafted, the Bill exempts IHS from the Plan. By exempting IHS, the Bill is saying that IHS would continue as a separate entity and would receive separate appropriations, but would not be entitled to reimbursement by the NHI program for direct care services. However, members of the Congressional staff working on the Bill indicated that this is not a fixed position and that proposals and suggestions for changes in the Bill's approach to Indians from the Indian community would be welcome. The Plan would take care of almost all the health care needs of urban Indians and Indians with access to private health providers. The Bill would require all persons, including Indians, to pay a 1% payroll tax for health services.

b. Long-Ribicoff Catastrophic Health Insurance and Medical Assistance Reform Bill

Description

The Long-Ribicoff Catastrophic Health Insurance and Medical Assistance Reform Bill is based on the position that the Health Security Bill is too comprehensive and too expensive to implement in one package at one time. Rather, a fully comprehensive NHI should be developed incrementally, starting with the two most serious health financing concerns: the devastating financial effect of catastrophic illness on almost all families and the health needs of indigent persons. The Catastrophic Health Insurance section of the Bill proposes to put a ceiling on the amount any family, regardless of income, would have to pay in medical bills in one year. A federal insurance program would be set up through payroll taxes on employers and employees. After a family had incurred $2,000 in medical bills in a year, the insurance would pay 80% of all additional medical bills. After the consumer had paid an additional $1,000 in coinsurance, the Plan would pay for 100% of health costs. The insurance would be administered, like Medicare, through the Social Security System. Medicare and other federal health programs would be continued.

The second component of the Long-Ribicoff Bill is the Medicare Assistance Plan (MAP), a program of health care for the poor to replace Medicaid. Under the present Medicaid system, there are wide disparities among the states in costs, benefits, and eligibles, producing a system with which neither the states, the federal government, nor the eligible population are particularly happy.

The MAP proposal would federalize the Medicaid program. There would be a standard, nationwide benefit package and standard eligibility requirements, both of which would be much more far-reaching

than presently found in most states. A family of four with a yearly income under $4,800 would be eligible. This figure goes up $400 for each additional family member. The proposed benefit package is comprehensive, including preventive care, although not as comprehensive as the Health Security Bill. There would be a three dollar copayment for each of the first ten visits to a doctor per family per year (but no copayment for visits to well-child and family planning services). The federal government would pick up all costs above what a state is presently paying in Medicaid costs. The federal contribution would be financed from general revenues. The Plan would be administered by the Social Security Administration. Estimated new costs would be $5.3 billion.

Impact on Indian Health

As presently drafted, the Catastrophic Insurance component of the Long-Ribicoff Bill would have minimal impact on Indian health. The Bill's provisions do not come into play until a family has spent at least $2,000 on medical care. To be useful to IHS and the Indian population that it serves, the Bill would have to add a provision allowing Indians to be covered after IHS has spent $2,000 on a family (since few IHS-served Indians spend $2,000 a year on health services). This would require IHS to set up a bookkeeping system to keep track of charges, a potentially costly process given the limited reimbursement IHS would likely receive. On the other hand, the Medical Assistance Plan would have a substantial impact on the financing of health services to Indians, though not as much as would the Health Security Bill. According to the 1970 Census, approximately 50% of all rural (i.e., reservation) Indian families earned less than $4,800 a year. Since the eligible income ceiling goes up $400 for each additional family member above four, and since rural Indians have the largest family size of any group in the country, at least 55% to 60% of the Indian population presently served by IHS would be covered. Therefore, over half the IHS service population could use MAP instead of IHS contract care funds for services needed outside the IHS direct care system that are covered by the MAP benefits. (A much smaller percentage of Indians are now eligible for Medicaid and the benefit package is not as broad.) The three dollar per visit copayment is minimal and could be covered out of IHS's funds. As presently written, IHS would not be reimbursed by MAP for services it provides through its direct care system. The Bill provides that MAP, like Medicare and Medicaid, would not reimburse federal health facilities (which presumably would include IHS, unless specifically exempted from this restriction). The Catastrophic section of the Bill would require Indians to pay a payroll tax for the health insurance.

c. Administration Bill

Description

The Health Security and Long-Ribicoff Bills propose programs in which the provider is reimbursed directly by the federal government. The Administration Bill proposes to use the private health insurance industry to provide the coverage and do the reimbursing. The proposal has three components--the Employee Health Insurance Plan, the Assisted Health Insurance Plan (AHIP) and Medicare.

The Employee Health Insurance Plan would require an employer to arrange with a private insurance company to make a minimum health insurance package available to all its employees. The employer would pay 75% of the cost of the private insurance premium and the employee, 25%. The employer must offer the Plan but the employee participates only if he or she wants. The insurance package would be required to provide a comprehensive benefit package, although the minimum required is less comprehensive than the Health Security or Long-Ribicoff proposals. A family of three or more must pay the first $450 of costs for covered services. Each person would also pay a copayment of 25% of all costs covered by the insurance, but no family would be required to pay more than $1,500 a year in deductibles and copayments. (Premium costs are additional.)

The second part of the program, the Assisted Health Insurance Plan (AHIP), would provide health insurance to individuals who cannot obtain coverage privately, either because they lack the financial resources or are in poor health. For such persons, the government would pay part or all of the premium and some part of the deductibles and copayment, depending on the person's income. For example, a family with an annual income of between $2,500 and $4,999 would pay no money for premiums, a $50 per person deductible for health care, and a $25 per head deductible for drugs, and then a 15% copayment. The total maximum cost to families in this income bracket for deductibles and copayments is 9% of the family income. Thus a family of four earning $2,500 would pay a maximum of $225 a year; a family earning $4,999, a maximum of $450. AHIP would be administered by the state governments and would be financed through joint state and federal contributions. Medicaid would be abolished but Medicare would be retained and expanded.

Participants in all three components (EHIP, AHIP, and Medicaid) would receive a health card on which to charge all deductibles and copayments. Therefore, they would not have to pay any money out-of-pocket when they see a doctor. The providers would be paid in full by the insurance companies who would then bill the consumers for the deductibles and copayments. For persons on AHIP, the state would use a private company to collect the bills, but the bill would be legally owed to the state, not to the company. Under the Administration Bill,IHS could not receive NHI reimbursement for services it provides through its direct care program.

Impact on Indian Health

Under the Administration Bill Indians would participate and contribute to the Plan only if they choose to, either by purchasing coverage through the plan offered by their employer or by enrolling in the AHIP for low-income persons. Employed Indians earning over $5,000 a year who use IHS would have little reason to participate. They would be paying premiums out of their wages and yet have little opportunity to use the insurance coverage since they use the free services at IHS. For families earning less than $5,000 (55%-60% of the IHS service population), there would be no premium costs. If these families enrolled in AHIP, and if IHS paid the deductibles and copayments as it does now, NHI would become another resource to stretch significantly the IHS contract care budget.

However, the Bill assigns administrative responsibility for AHIP to the states. In administering the Medicaid programs, the states have been most reluctant to grant Indians the benefits to which they are entitled. These problems could very likely reoccur under state administration of AHIP.

d. The Kennedy-Mills Bill

Description

The Kennedy-Mills Bill was developed as a compromise between the Health Security Bill and the Administration Bill. It would be administered by the Social Security Administration. The Bill would not use private insurance policies as the primary insurer, but would have the federal government reimburse the providers directly for all citizens. Financing would be achieved through a payroll tax on employees (1%) and employers (3%). Participation would be compulsory for all those covered by the Bill. However, participation would not be universal. A person would be covered by the Plan only if he fell into one of the eligibility categories established by the Bill. The categories would include most but not all of the population--those who are employed, self-employed, have unearned income, work at least one week a month, or are on AFDC or SSI.

There would be a deductible of $150 per person up to a maximum of two deductibles ($300) per family. There would also be a co-payment of 25% on most services. There would be maximums set on the total amount of copayments and deductibles a family would have

to make a year, depending on the family income. A family of four earning under $4,800 per year would pay no deductibles or copayments, but would still have to pay the 1% payroll tax. For families of four earning between $4,800 and $8,800 the maximum amount of co-payments and deductibles and would be 25% of the difference between their incomes and $4,800. For a family of four earning over $8,800, the maximum cost for deductibles and copayments would be $1,000.

The Plan would use a health card system similar to the one in the Administration Bill. However, the consumer would owe the money to the federal government rather than to the state or private insurance company as provided for in the Administration Bill. IHS could not be reimbursed for direct services provided. Medicaid would be abolished but Medicare would be expanded to include a long-term care program for the elderly.

Impact on Indians

As with the other Bills, the main benefit of the Kennedy-Mills Bill to the IHS service population is that it would supplement the IHS contract care budget. Low-income Indian families would pay no deductibles or copayments. However, they would have to pay the 1% tax on income to be eligible for coverage under the Plan. While IHS has paid deductibles and copayments for Indians who have third party resources, it has never paid premium cost, or in this case, a payroll tax. Indians would be paying the tax, yet receiving little benefit in return, since they are already entitled to IHS contract care services. While it would stretch the IHS contract care budget in general, there is no guarantee that it would directly benefit those Indians paying the tax. Therefore, they would end up subsidizing the IHS contract care budget.

A second problem with this Bill is that the coverage is spotty. Many Indians would not be covered by the eligibility categories created by the Bill. It would exclude Indians who work only seasonally, those on BIA general assistance, those who are unemployed (and not on AFDC or SSI), possibly the Indian farmers, ranchers, silversmiths, and those living on lease income. In some ways this would be a benefit to them since they would not have to pay the 1% tax. But from the point of view of health care to Indians, there seems to be no logic in making the coverage and the tax compulsory on some Indians while excluding other Indians.

The Impact of NHI on Basic Indian Health Rights

The four Bills differ substantially in the specific ways that they would impact the existing Indian health system. However, the primary Indian concerns about NHI are not on these specific

issues but at a much more basic level. As the most comprehensive federal health program, NHI cannot help but have a significant impact on the existing federal-Indian relationship on health. Intentionally or not, it is bound to have an effect on the historical right to free federal health care, on the continuation of the IHS direct care delivery system on reservations, on the right of tribal self-determination in health. If an NHI plan is to be acceptable to Indians it must deal consciously and specifically with these concerns, and insure, to the extent possible, that NHI will further, and not erode, the existing Indian rights in the area of health. None of the NHI Bills deals with these basic concerns or contains provisions to insure that NHI will not have a destructive effect on existing Indian rights. Indians have a unique health system and need to be dealt with in a separate section of any NHI legislation. The history of Indian affairs demonstrates that where general legislation does not specifically and separately deal with the unique nature of Indian rights, it ends by diminishing those rights.

To avoid the unintended negative effects of NHI on basic Indian health rights, there are several possible options available to the Indian community: 1) It could seek to get Indians completely exempted and removed from NHI and continue under the present Indian health system; or 2) It could try to develop an Indian section for the Bill which satisfactorily deals with Indian concerns. If it chooses the first alternative, it must seek changes in the Bill to exempt Indians from the payroll tax 1/ and from other effects of the Bill. If it opts for participation, it must develop an Indian approach to NHI which will insure to the extent possible that NHI is compatible with the Indian's right to free federal health care, provides for the continuation of the IHS delivery system and offers special funding to meet the special health problems of Indians, and the right of tribal self-determination in health. The Indian community must evaluate the potential impact of NHI on these basic issues, weigh the pros and cons, make a choice between the two alternatives, and then work to implement that choice. The least desirable of all options is if there is no Indian action on the Bills and one of them passes in its present form.

In evaluating the advantages and disadvantages of the options, and developing a possible approach for Indian involvement in NHI, the discussion is intended as a basis for further dialogue on a subject which will require a significant amount of debate before a final position can be reached.

1/ For the three Bills that impose a payroll tax: Kennedy-Mills, Long-Ribicoff, and the Health Security Bill.

3. Indian Exemption from NHI

Complete Indian separation from NHI would require a provision permitting Indians who use IHS the option of not participating in the program and of not paying the tax. IHS would not receive reimbursement from the program, and a commitment to the separate funding and continuation of IHS direct care services would have to be included in the Bill. The arguments in favor of Indians separating themselves from NHI include:

- NHI would require Indians to pay a specific tax for health services. This would place a financial burden on Indians who now use IHS at no cost to themselves. It would also change the historical commitment of the federal government to provide free health care to Indians--a change which might gradually widen until the commitment disappeared.

- Indian inclusion in NHI could lead to the gradual termination of separate federal funding for Indian health needs. As NHI becomes the primary health financing mechanism for Indians, the federal government could easily lose sight of the need for the separate additional funding for Indian health that it now provides through IHS. There are no funds in NHI to help overcome the geographical and cultural distances that handicap the delivery of health services on reservations, to provide for special outreach programs and sanitation services, or to facilitate the Indian involvement program. Coupled with the extent of poverty and the high disease rates on reservations, geographic and cultural distances make health care for Indians much more expensive than for any other service population. Even if NHI reimbursed IHS for all its direct care and contract care costs, separate funding would still be needed to cover these special needs of Indians. Yet, special Indian health programs could easily be absorbed into the general reliance on NHI for health financing, and the separate funding for Indian needs might gradually disappear.

- NHI endangers the continuation of the IHS direct health delivery system on reservations. On many reservations IHS doctors, hospitals, and pharmacies are the only ones available to most of the inhabitants. Private providers and facilities are often inaccessible, may be insensitive to Indian values and needs, and are not subject to Indian influence or control. Under the self-determination policies, tribes have the option of assuming

control of the IHS facilities. But they must have the opportunity to assume that control at their pace, and not be forced into it because of pressures created by NHI. Self-determination also includes the option of not assuming control and letting IHS continue to provide direct health care to tribal members.

NHI is a financing mechanism exclusively. It does not deliver services, build hospitals, or hire doctors. The danger to Indians is that at some point the distinction between a financing system and a delivery system will become obscured. There are already pressures within HEW to move the federal government out of the direct delivery of health care. Officials favoring such a policy could argue that Indian participation in NHI takes care of Indian health needs and that the IHS direct care system is no longer needed. The history of federal Indian policy indicates that the subtle distinctions and unique needs of Indians tend to be ignored, when a larger national policy is being implemented. The IHS direct care system could easily become a victim of this tendency. Termination of IHS would force tribes to either administer the system themselves, in violation of self-determination, or rely solely on the inadequate private medical system available.

The arguments in favor of Indian participation in NHI include:

- NHI could add millions of new dollars for health care to Indians, (if IHS can be reimbursed for direct care services). The dollars could be used to make up the 30% shortfall IHS now operates under and thereby end the inadequacy of the services, the erratic benefit package, the long waiting lines in the out-patient clinics, the grossly inadequate facilities, etc. Indians cannot afford to ignore this money, since the only alternative is to wait until the federal government fully funds IHS, a possibility which does not now look promising. Non-participation in NHI would relegate Indians to a permanent second-class status in health, while the rest of the country's health system moves forward under the propulsion of NHI.

- If some of the NHI money could be funneled to the tribes, it could be used to underwrite the self-determination in health sought by Indians. Presently there are inadequate funds for the development of tribal health administration development; tribal control over IHS is illusory since the IHS budget is so fixed and so short that there is no room for significant tribal input. NHI could provide a new flow of money, through which the tribes could implement their own priorities.

- It is not politically feasible to exempt Indians completely from NHI. Congress would not accept a plan that apparently discriminates against Indians and apparently structures second-class status for Indians in health. Even if Indians themselves opted for such a model, it would be unlikely that Congress would take the time to understand the validity of such segregation.

- Finally, NHI is likely to affect Indians whether they participate in it or not, and therefore, it is better to participate and shape it as much as possible to Indian needs, rather than to stand outside it and try to divert its impact. As NHI becomes the country's primary health program, availability of doctors and other health services will be affected, thus in turn affecting IHS. There is no language that will bind future Congresses on Indian separation from NHI. Therefore, the best way to protect against the potential dangers to sovereignty, self-determination, and the special relationship is not to repudiate or ignore NHI, but rather to participate in it, by building into it as many protections as possible to minimize the dangers.

Conclusion

The conclusion reached here is that Indians should opt for full participation in NHI and work to shape the pending legislation while the legislation is in the developmental phase, in order to maximize the benefits to Indians and protect against the threats to basic Indian policy. The position is based primarily on the determination that NHI is going to impact Indian health systems one way or the other, and therefore, it is better to use NHI for the advantages it can bring, rather than ignore it. Secondarily, it is based on the potential NHI offers, if properly tapped, for providing the kind of high quality health care that the federal government has been unwilling to fund IHS to provide directly. On the other hand, there are real dangers inherent in NHI for Indians, and any Indian position on NHI must be analyzed thoroughly and discussed by the Indian community before it is finalized.

4. Developing an Approach

An Indian approach to NHI must be written in a way that preserves and furthers the basic Indian concerns discussed above. Specifically, it must be shaped in such a way that it:

- Preserves the direct delivery system on the reservations, whether run by IHS or the tribe. The participation must be in a form that makes the continuing need for a direct delivery system conspicuous, whatever the financing system used, so that the distinctions between a delivery system and a financing system will not become blurred, and so that the delivery system will be continued.

- Preserves the special funding for Indian health needs as part of the unique federal commitment to provide health services to Indians. The participation should allow for a visible distinction between the health needs being met through NHI resources, and the special health needs requiring a separate Indian appropriation.

- Provides enough new health funding to Indians to make the risks of participation worth it. In particular, it must provide that IHS and tribes get reimbursed for direct services they provide that are covered by NHI. There is no question but that additional funds are needed for Indian health. IHS acknowledges that it has only 70% of the funds it requires to meet immediate needs. If Indians cannot be reimbursed by NHI for direct services, this 30% shortfall will remain, and Indians will end up as NHI's step-children--paying their full dues, but receiving less adequate services than other NHI participants. If Indians are required to pay an NHI payroll tax, there is no excuse for prohibiting reimbursement to IHS and tribes for covered services provided by them.

- Is compatible with the basic premises of self-determination. It should further the opportunity for tribes to be involved in their own health programs and to have as large a voice as they deem appropriate in influencing the method of health services delivery. Without a uniquely Indian health system--whether operated by IHS, by the tribes, or by IHS with the tribes controlling the planning, monitoring and evaluation of the system--it is impossible to say what self-determination means. Control over community hospitals, shared facilities, or contract medical service has not in the past proven to afford Indians the opportunity for such control. Self-determination also requires that no authority over tribes or services to Indians be given to state agencies.

5. Suggested Approaches

The most common approach suggested for Indians and NHI is for IHS to pay the taxes and deductibles, bill NHI for covered services it provides to eligible Indians, and then obtain reimbursement from NHI to use in addition to the funding it receives directly from Congress. However, there are several problems with this approach. First, when a similar approach was raised for Medicare and Medicaid, OMB indicated that it would reduce IHS direct appropriations in proportion to the amount it received from those programs, which meant a zero net gain for IHS. Secondly, it is the approach most susceptible to the charge of duplication. If the money from NHI and the money from Congress went into the same IHS pot and were used for the same general services, Congress could begin to ask why the need for two separate funding sources and gradually phase out the special funding of Indian health and leave it all to NHI. There is the need for an approach that highlights the special health needs of Indians as against the general needs provided for in NHI. Thirdly, this approach does not aid the tribe in achieving greater involvement in the health area.

An alternative approach would be one that separates the two different sources of funding (NHI and special Indian health money) by directing each source of funding to a different recipient to be used for different purposes. There are several ways this can be done. One way is to have IHS continue to receive its separate funding from Congress. IHS would bill NHI for covered services it provides, but rather than keeping the reimbursement itself, it would assign the NHI proceeds to the respective tribes to be used by them for tribal self-determination in health. Under a second alternative, IHS could be funded solely from NHI reimbursement and Congress could fund the tribes directly with the money that is now going to IHS. Either way, Indians would be receiving the funds they are entitled to as contributors to NHI and the funds they are entitled to based on their special relationship with the federal government. (See diagram on the following page for a simplied explanation of these approaches.)

Source of Funds		Recipient		Purpose
Option #1				
Congressional appropriation for Indian health	to	IHS	for	Basic health services package
NHI reimbursement for eligible Indians served by IHS	to	Indian tribes	for	Special Indian health needs as determined by the tribe
Option #2				
Congressional appropriation for Indian health	to	Indian tribes	for	Special Indian health needs not covered by NHI, as determined by the tribe
NHI reimbursement for eligible Indians served by IHS	to	IHS	for	Basic health services covered by NHI

(Reimbursement for services obtained by Indians outside of IHS facilities, either privately or through contract care, would to directly to the private provider and not involve these options.)

Separating the two sources of funding in this way decreases the likelihood that they will lose their separate identities, and eventually be seen as substitutes for rather than as supplements to each other. It also gives IHS a clear role under NHI so that NHI cannot be used to argue that IHS is no longer needed. Such an approach would put money into the hands of the tribes and, through the tribes, to the Indian Health Boards or health departments and thereby change their present illusory authority over health into real authority and power. Rather than have the tribes' health authority and resources provided by and subject to the control of IHS, the Boards would control part of the health monies being spent on their reservations, with the power to determine how that money should be spent. Additionally, the use of the funds controlled by the tribes would permit the tribes to influence IHS performance, and thus, to become truly equal partners with IHS on Indian health. These approaches would also insure that Indians receive both of their entitlements in full; their entitlement as citizens and as contributors to NHI through the payroll tax, and the special entitlement that flows from the historical and legal relationship between the federal government and Indians to meet the special health needs of Indians.

Under the first option, tribes, IHS, and Congress would define a basic benefit package which Congress would fund at a level that would insure services to all eligible Indians who needed them. Since IHS would be eliminating certain programs, the money saved could be used for the basic package, and thus the package could be funded without a significant increase in the existing IHS budget. The tribe would receive the reimbursements for NHI-covered services provided by IHS and use it to provide the health services not being provided by IHS which the tribe identified as its priority needs.

Under the second option, IHS would provide all those services specified in the NHI benefit package. Since it would be reimbursed by NHI for those services, it would have the funds to provide them to every Indian who needed them. NHI does not cover sanitation, health education, transportation, Health Board development, and certain outreach programs, (and perhaps facilities construction), so IHS would be unable to provide those services. Instead those services which constitute the special Indian needs would be provided by the tribe if it so chose, with funds appropriated by Congress, through IHS, to the tribe. The tribe would also use the money to provide other services that it considers priorities. The funding process would be similar to the one used in Manpower Revenue Sharing (CETA). 1/ The tribe would submit a plan for a health program to IHS for approval and funding. The amount of funding to each tribe would be on a per capita basis. The National Indian Health Board could be assigned the responsibility for assisting tribes develop their plans. Under

1/ Comprehensive Employment and Training Act of 1973.

this approach NHI would be funding IHS to provide Indians the services they are entitled to as citizens. Congress would be funding the tribes to meet those special health needs to which the federal government has committed itself to provide to Indians as part of the special relationship.

Under either option, resources coming to the tribes would be spent on additional health needs, as defined by them. The tribe would be able to define its own priorities and would have the resources to develop specific programs in response to those priorities, rather than seeing its efforts ignored by the SUD, or not carried out because the resources have all been committed before they reach the Service Unit level.

This approach would give tribal Health Boards the power, through fiscal control, to shape the reservation's health program according to Indian needs and priorities. They could continue those IHS programs which are not in the new IHS package but which they decided, on a priority basis, were worth continuing. If the Health Board decided that a health education or a nutrition program was less important than a transportation system to get Indians to the clinics, it could let the former programs drop and direct its funds to a transportation program. An extended phase-in period would be required to insure that, as IHS discontinued its non-package programs, the tribe would have the opportunity to continue any program on its list of priorities. If a Board considered alcoholism to be its number one priority, it would determine the amount of money to be allocated to alcoholism programs. If the basic package provided by IHS did not, in the opinion of the Health Board, sufficiently reduce waiting time in the clinics, it could use its funds to hire an additional doctor or paramedic to work in the clinic with the IHS staff to speed up services. If it is felt that health services should be more culturally oriented, it could pay a traditional Indian medical practitioner to serve with the IHS doctors. Or if it were concerned about having a sufficient supply of doctors, it could even use some of its funding to send tribal members to medical school.

Thus, the Boards would be making priority decisions in the real world, where the selection of one priority means that funds would not be available for other programs, as against the present artificial, and therefore, unrewarding atmosphere in which they make lists of priorities not tied to available funding. The Boards could also use the NHI funds to receive training and/or to hire expert staff to help them make reasoned judgements in response to the challenges offered them. Since IHS would be providing the basic health care services with different funds, the Health Boards would be able to implement their priorities without the fear sometimes posed on them by IHS staff, that if they made such decisions, some critical life-and-death program would be terminated.

This approach would enable Indians to get the resources in full from both their entitlements, NHI and IHS, while maintaining the separate identity of each. In addition, it would reshape the entire Indian health system, so that IHS and Indians would be equal partners in Indian health. It would give tribes the resources they needed to achieve self-determination in health care, to shape the kind of health program they wanted on their reservation. With a prescribed package of services, IHS in turn, could be held directly accountable to the Indian people, and thereby be made more responsive to Indian needs and values.

The approach does not, however, create a self-determination that is forced on a tribe. Self-determination in health would permit a tribe or Health Board that did not want to assume these responsibilities to turn its resources over to IHS to allocate, or it could contract with IHS or a private health institution to provide the identified services.

III. I. HEALTH MAINTENANCE ORGANIZATIONS

The Health Maintenance Organization (HMO) is a system for organizing and delivering health services. It was developed in the private sector as an alternative to the prevailing fee-for-service system. Traditionally a person with a health problem receives services from a solo practice physician and pays him a fee for the specific service rendered. An HMO 1/ uses a prepaid group practice approach to health services, in which the consumer prepays a fixed monthly amount for services, and the services are provided by a doctor who practices in a medical group, rather than by a doctor who works in his own practice. During the interviews conducted for this study, there were frequent references to HMO's by tribal leaders and IHS staff, and questions raised about the role of HMO's in the future of health services for Indians. This section addresses some of those questions.

HMO's are usually private organizations (as against governmental agencies), and operate on money that comes from monthly fees paid by the HMO subscribers (users). Thus, the HMO combines the elements of a health delivery system with the elements of a health insurance system because it not only assumes the responsibility for providing services, it pays for the services as well. Advocates of the prepaid group practice approach to health delivery feel that it has a number of advantages over the fee-for-service method of delivering care. An HMO provides a broad range of services under one roof, group practice insures peer review of the treatment provided, it provides unlimited services for a fixed monthly rate, it has no incentives for the doctors to engage in unnecessary medical procedures just to obtain an additional fee, and it has other incentives to keep down the cost of providing health care at a time when the cost of care is skyrocketing.

An HMO is not a federal program for financing health services or a potential third party resource for Indian health. The 1973 HMO Act 2/ provides federal grants for feasibility studies and planning, and loans for operational costs during the first three

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1/ The HMO Act of 1973 also refers to foundations, which are prepaid systems in which doctors are in individual practice but are tied together through financial arrangements which permit consumers to prepay for services. The discussion that follows refers only to the group practice form of HMO. We have determined that the group practice system is more relevant to Indian concerns and that a proper discussion of foundations would overly complicate an already difficult series of facts.

2/ P.L. 93-222 (1973).

years of operation, but it does not provide funds for ongoing delivery of services.

Prepaid group practice programs have been operating for a number of years in different locations throughout the country. Each program adopted its own mixture of the various elements of the prepaid group practice concept in order to meet the particular needs and preferences of the Area in which it was located. The 1973 HMO Act, however, gave a specific legislative definition to the term "Health Maintenance Organization". According to the Act, the essential elements of an HMO are: (1) specified comprehensive health benefits, (2) a voluntarily enrolled population, (3) prepayment, and (4) services provided by a medical group. This definition is relevant, however, only if one's objective is to obtain some of the limited federal assistance available in the Act. If the intent is to reorganize and improve the health delivery system now serving Indians by adopting or adapting some of the ideas that have proven successful in HMO's, then the Act's legal definition does not apply. Rather, the HMO structure should be examined as a flexible concept that can be useful to Indians in developing their own health delivery system.

In this section the HMO definition in the Act is utilized, but solely as a point of reference for our discussion. It should also be noted that IHS and HMO's have many elements in common, and are more similar to each other than either is to the traditional fee-for-service system. At relevant points in the discussion, comparisons are made between HMO's and IHS. Our objective in so doing is not to indicate that one system is better than another. That is a complex question involving many factors: location, characteristics, size, and needs of the service population, etc. The comparison is provided solely to clarify the description of an HMO by comparing it to the more familiar health delivery system of IHS.

1. The Elements of an HMO

a. Comprehensive Benefits

An HMO guarantees to deliver (within reason and, for specialist services, upon referral by a primary-care physician) a comprehensive range of health services to its subscribers. The services to be provided in the comprehensive health benefit package are spelled out by each HMO as part of the contract between the HMO and its subscribers. While the benefit package will vary among HMO's, the 1973 Act sets some minimum standards, requiring HMO's (in order to be eligible for funding under the Act) to provide both basic and supplemental health services, including diagnostic, curative, therapeutic, and emergency services, plus

home health services, social services, health education and prescriptive drugs. Some HMO's may also have a policy that, if the waiting time for services exceeds a certain limit, the HMO is required to add an additional doctor. Within certain parameters, an HMO subscriber has unlimited use of these services during his enrollment.

In contrast to an HMO, IHS does not offer a comprehensive benefit package to all its service population. The types of services available vary among the Service Units, and, due to a shortage of funds, some services which IHS is supposed to provide cannot be delivered to all eligible persons. Under the comprehensive benefit package requirements, an HMO would have to provide otitis media operations to all persons requiring one if such an operation were included in the benefit package. If the HMO did not, it would be open to a law suit by the person denied. If the HMO did not have the money to perform all the needed operations, it would either go out of business or be required to raise its premium rates. It should be noted that to be an HMO, it is not necessary to offer a "comprehensive" benefit package. Such a package could be developed under the present IHS structure given modifications in the IHS planning, budgeting, and staffing procedures.

On the other hand, IHS does provide a wide range of services including preventive services and, like an HMO, tries to maintain people at a healthy level rather than to just treat people who are already sick.

b. A Voluntarily Enrolled Population

Most persons become HMO subscribers through a plan that is available to them as a fringe benefit of their employment or through Medicaid or Medicare. The cost is usually shared by the employer and the employee. Persons should be given a choice by their employer of joining the HMO, or of obtaining a health insurance policy that will reimburse their use of an individual doctor on a fee-for-service basis. The voluntary population thus enrolled works to the benefit of both the subscriber and the HMO. The HMO does not have to serve disgruntled subscribers who are using its facilities because they have no other option from which to choose. An HMO sells a product--health care--and must satisfy its customers in order to stay in business. One of the incentives for providing high quality, dignified health services is to keep customers enrolled in the plan. If the subscriber cannot go elsewhere when dissatisfied, the HMO theoretically has less incentive to provide good service to its membership.

A subscriber is usually permitted to reconsider his membership only once a year. This is especially important to an HMO, because it is thereby assured a defined, relatively stable population base and funding source upon which it can make planning and staffing decisions.

For most Indians who use the services of IHS, there is no voluntary enrollment. Congress allocates the funds directly to IHS; it does not give the individual Indian a choice of using his share of IHS funding allocation to buy health services from another provider. 1/ Even if Congress were to make such a choice possible, for many Indians there are no alternative health delivery systems or doctors readily available. IHS thus has a captive population and is not an HMO in this regard. Two facts should be noted. An all-Indian HMO would have the same predominately captive population which the IHS now serves. First, an HMO will not change the realities of delivering health care to isolated communities. Second, the Indians are not very different from other population groups living in rural areas (particularly low income groups) who have only one doctor available to them, if they have a doctor within a reasonable distance at all. Most HMO's have provided service to highly concentrated urban populations, although a few organizations in rural areas are beginning to emerge.

c. Prepayment

The prepaid (monthly or annual) dues or premiums cover the cost of all services provided in the comprehensive benefit package, usually with no additional charges to the patient at the time services are rendered. 2/ The subscriber may use the services as often as he requires them at no additional cost. The element of prepayment effectively eliminates the barrier often created when a person must pay a fee at the time he seeks services. Many people, particularly low income persons, put off going to a doctor until they are really sick because they do not want to spend money on a doctor unless it is absolutely essential. Since there is usually no out-of-pocket cost at the time of service for the HMO subscriber, he should be more inclined to seek early treatment for a medical problem and thereby minimize the development of acute problems.

1/ Section 6b of the 1973 HMO Act gives the Secretary of HEW the authority, with the consent of the Indian people served, to contract for the provision of health services with non-IHS organizations on a fee-for-service, prepayment or similar basis. This means that IHS may contract with an HMO to provide services to Indians. It does not give the individual Indian the freedom of choice to enroll in an HMO and require IHS to pay the premium.

2/ Some HMO's do charge their subscribers a small copayment fee every time they use the services, and the 1973 HMO Act permits but does not require copayments of up to 50% for all services.

Prepayment requires that the HMO assume a financial risk: if the actual cost for delivering services is higher than the premiums paid, the HMO will face serious financial difficulty. Therefore, the HMO must institute strict budgetary and operational controls, and determine, in adviance, what the likely cost will be to deliver the agreed-upon package of services to any member who requires that service. Since the HMO is not compensated on a fee-for-service basis, there is no incentive to provide unnecessary services. In fact, there is a disincentive to do so, since it would be an inefficient and wasteful use of predetermined and limited resources.

The HMO has an incentive to provide and encourage the use of preventive services since it is cheaper to maintain a person in good health than to cure a sick person. Early and responsible treatment may mean fewer hospital admissions, hospital care being the most expensive method of rendering health care. Since IHS has been oeprating with a backlog of contract care services for many years, it should be recognized that any Indian HMO would have a very heavy service load during its first few years of operation.

d. Medical Group

The HMO delivers services through a medical group. The group may consist of physicians who are employed by the HMO, or are under contract as a group to deliver services to HMO enrollees. The doctors work as a group out of a clinic, similar to IHS doctors. When a specialty service is not provided by the medical group, the HMO will contract with a specialist separately to provide the number of days of the specialist's service required by the HMO subscribers per year. His fee does not vary according to how many patients he treats, decreasing any incentive on his part to perform unnecessary operations, and making the HMO's budget predictable. The HMO, using health utilization data, estimates how many of its subscribers are likely to need the services of that specialist over the course of the year and then determines the number of days it employs the specialist.

In many HMO's the doctors themselves are "at risk". That is, if the HMO provides services efficiently and economically and thereby spends less than it collects in premiums, the doctors share the surplus. Thus the doctors have a personal financial incentive to provide good care that prevents illnesses before they become acute, and thereby require expensive treatment. There is also a financial incentive in keeping the patient satisfied, so (s)he remains a subscriber.

e. Enrolled Population

Much of the discussion about the feasibility of HMO's centers around the size of enrollment that is needed to make an HMO economically viable. An HMO needs a large and varied population to be able to spread its risk. Perhaps more importantly, it needs a relatively large enrollment to be able to generate enough money to cover its fixed costs such as facilities, equipment, laboratories and specialists. Like many other businesses, an HMO has a "break-even" point, the point at which the number of subscribers (customers) will be large enough to cover the fixed costs; an income greater than that will produce a surplus or "profit;" less than that will result in a "loss," or make it impossible for the system to continue in operation. The estimated enrolled population for an HMO to reach its break-even point is 25,000-40,000. 1/

As an alternative to an enrollment that large, an HMO could raise its premiums, but that would make it less competitive with other systems of paying for health services (such as health insurance), and therefore likely to attract fewer customers. Or, it could reduce its staff and contract out for services from private doctors, particularly specialists, on a fee-for-service basis or even contract for a certain number of man-days per year. But this approach is inimical to one of the basic concepts of an HMO--control over its physicians and control over its costs in order to insure high quality care at reasonable costs. The more it sends its subscribers outside the HMO for services, the less control it has and the less benefit to the subscriber in being a member of the HMO. Therefore, for a complex combination of financial and health system reasons, HMO's are thought to work best when they have an enrolled population of 25,000-40,000. The 25,000-40,000 HMO population is predicated on a concentrated urban population including an average cross-section of the working population. An increase in the number of delivery centers needed to serve the population increases either the unit cost or the size of the service population necessary to break even.

Given the higher level of disease on Indian reservations, it is likely that the stated enrollment figures are too low if applied to Indians to "break even" at the going rate for HMO premiums. The staff that would be adequate to serve 25,000 middle-class Americans would not be large enough to serve 25,000 reservation Indians. Children and elderly require more medical care than does the population between 15 and 64 years. Rural Indians have

1/ This is total number of persons, not subscribers. A subscriber is a family unit. So 25,000-40,000 persons would equal about 5,000-8,000 subscribers, using the average family size for the United States of three persons per family.

fewer elderly in their population, but 42% of the population is under 15, compared to 28% in the general population. Increased birth rates also increase the cost of serving a fixed population. The birth rate for Indians is 33.0 per 100,000 women, compared to the U.S. average of 17.3 per 100,000 women.

One of the reasons IHS has such high costs is that it is working with small Service Unit populations--from 1,000 to 6,000 in most Service Units, and therefore is not functioning at the most economical level for a health delivery unit. In particular it is too small a population to make economical use of full-time specialists. As a result IHS employs specialists on a fee-for-service basis through the contract care program. As with HMO's IHS finds that this wreaks havoc with its budget, because it is expensive and unpredictable. It also gives IHS inadequate control over the medical services its consumers receive from its contract care physicians. IHS doctors spoke frequently about the problems they had trying to monitor the services provided by the doctors hired under the contract care program and the fears they had that the contract care doctors were providing unnecessary services to Indians in order to run up their bills. In those Areas with a regional medical center, however, the centers serve a large enough population (most or all of the SU's in the Area) to make it economically justifiable to employ specialists on a full-time basis, thereby increasing the viability of an HMO in those Areas.

2. HMO's and Indian Tribes

The questions asked by many tribal health planners and tribal leaders during the interviews was what role the HMO concept could play in the process of Indian self-determination in health; is the HMO a viable system for tribes that want to take over operational responsibility for health delivery from IHS? There are at least two ways tribes could utilize the HMO concept:

- Indian Membership in an Existing or Developing HMO

  A tribe could either join an existing HMO or work with nearby non-Indians to develop an HMO from the beginning. There are two different situations which must be considered here: (a) where a tribe now has IHS facilities and direct care on its reservation, and (b) where a tribe receives all its care, both inpatient and outpatient, from private providers through the IHS contract health services budget.

- A Tribally-Based HMO

  A tribe or tribes could convert the present IHS system on their reservations into a local all-Indian controlled and dominated HMO.

Each of these possibilities is discussed below:

a. Indian Membership in an Existing or Developing HMO

Where a tribe is located in or near a community which has an established HMO or is considering the development of one, it is possible that the tribe could purchase membership for its tribal members in it, or involve itself in the planning process for a new HMO with a view to eventual membership. Joining with residents of nearby towns is one way to achieve the 25,000 to 40,000 person enrollment that experts think is necessary for an HMO to be viable.

Contract Care Situations

Where IHS is presently contracting for care with private fee-for-service practitioners and hospitals, as it is for 44% of the Indians in the Portland Area, it is a relatively short step to contracting with an HMO to provide those same services. The Kaiser Plan has an HMO in Portland; tribes in that vicinity could negotiate with Kaiser to have it become a provider for those tribes. Such an arrangement would not be a new one for Kaiser which has in the past had an OEO contract for the delivery of care to a low-income population.

The Kaiser OEO contract included not only the payment by OEO of the premiums for a specific number of persons in the HMO, but also the funding of a range of supportive services including family health workers and transportation. A similar arrangement would be required should IHS or the tribe contract with Kaiser or any other HMO. Other HMO's in the country are also a possibility for such contracts, particularly in light of the growing number of HMO's which are contracting to deliver services to members of the Medicaid population. Prepayment for Indian membership by IHS or the tribe would involve basically the same situation.

There are several advantages to Indians of this type of contract. One is the fact that an assured comprehensive benefit package of health services would be provided to the Indians through the HMO. Furthermore, the HMO would have an obligation to deliver this comprehensive care in a responsive manner, an approach which is far more likely to yield relevant health care services than are contracted fee-for-service practitioners, since such contracts offer few guarantees of responsive care to the service population. In particular, they could obtain the preventive services that many of the tribes in the Portland Area are not now obtaining. It would provide for peer review, and thus, quite likely better quality medical care. The individual doctors now employed with contract care money do not have any peer review system, and IHS has had to use its own staff to review the performance of the contract care doctors.

There are several problems with this model. One is the need to develop a mechanism to insure Indian involvement in HMO decision-making. Otherwise health care for Indians would be simply transferred from one non-Indian controlled system (contract care) to another (HMO's). There will also be a need to insure that the services provided are culturally sensitive ones. The relationship of the tribe (which would be paying the premiums for its members out of money transferred form IHS) to the HMO board would have to be carefully worked out to insure substantial Indian involvement. Because Indians would constitute only part of the membership, Indians could not expect to obtain full control. On the other hand, Indian input into an HMO offers the potential for significant improvement in health care delivery when contrasted with attempting to monitor five or ten hospitals and many, many doctors as is presently the case in contract care areas.

A second problem is that most tribes are located in rural areas and most HMO's are located in urban areas where there are sufficient concentrations of persons to provide the needed enrolled population. It would seem that this approach would be most feasible for tribes near medium- to large-sized cities. However, the 1973 HMO Act provides funds to encourage the development of rural HMO's. As these start to develop, tribes in more dispersed areas may also have an HMO available or could participate in the development of one. Rural HMO's, however, are likely to be of the foundation (IPA) model, rather than the prepaid group practice model.

HMO's in Conjunction with Nearby Towns Where IHS Now Provides Direct Care

Where IHS is presently delivering services directly to Indians in a given locality, it is also possible that a tribe could join or help develop an HMO in conjunction with nearby towns or cities. For example, the Gila River Tribe, which is close to Phoenix, could enter into some arrangement with the HMO in Phoenix. Such a situation possesses the same characteristics as the model discussed above plus other issues of importance.

If an HMO were to accept the tribal population as part of its membership, it is likely that the HMO would need to utilize the existing IHS facilities on a purchase or rental basis as HMO satellite clinics for outpatient care, and use its city facilities for surgery and hospital care. Such an option might be very attractive to the HMO on the one hand since the facility is already in place and it could serve not only Indians, but also non-Indian HMO members in the vicinity. On the other hand, if the IHS facilities were not in adequate condition, the HMO might not be willing to take over a facility which would require expensive and frequent repair. The other options would be for

the HMO to construct new facilities, which would remove some of the incentive to involve Indians, or require Indians to travel to existing HMO facilities, which would almost surely mean a longer trip than they are now making to the IHS facility. Therefore repair and modernization of some of the existing IHS facilities would be necessary for tribes to be in a favorable bargaining position for entrance into existing HMO's.

Secondly, Indian tribes would have to work with and share medical services with the non-Indians in the nearby towns. Since some of the examples of prejudice against and mistreatment of Indians are evidenced in the border towns, it would require that some of these old problems be resolved and that more cordial relations be developed between the two parties. This is a lot easier said than done and presents a major obstacle to a joint HMO that is shared by the tribal members and the residents of a nearby town or city. Indians would be in the strongest bargaining position, in such a case, if they had good facilities and if the tribe participated in the initial planning of the HMO rather than joining an HMO that was already ongoing.

b. A Tribally-Based HMO

This model is the one that was of most interest to tribal leaders; they were attracted by the idea of an HMO model if the tribe took over the IHS program on their reservation. They were examining the relative benefits of creating an HMO to taking over the existing IHS system unchanged. There are a number of factors to be considered:

(1) Indian Control of the Health System. Since the HMO would be a tribal operation there would be Indian control over health delivery, and thus the opportunity for culturally sensitive care, employment opportunities for tribal members, Indian priorities, etc. But this would also be true if they took over the IHS system intact.

(2) Comprehensive Health Benefit Package. As an HMO, it would offer a defined benefit package that is guaranteed to all subscribers, i.e., all tribal members. Tribal members would then know exactly what services they could expect and the HMO would be obligated to deliver those services to them. However, a health delivery system does not have to be an HMO to offer a comprehensive benefit package. It could be provided under the present IHS system also. In either case, the delivery of the comprehensive package required by the HMO Act would likely necessitate a substantial increase in budget (or decrease in services). With the tribe running the health delivery system, the tribe could be reimbursed by third party resources, thus expanding available resources.

(3) Voluntary Enrollment. Voluntary enrollment could be possible on some reservations where nearby alternative providers exist. In such a case the tribe would have to offer to purchase health insurance for those tribal members who elected not to participate in the HMO. This could provide an outlet for disgruntled consumers who are in conflict with the doctors. It could also give the tribe a financial incentive to operate an efficient delivery system. However, as the governmental representative of the tribal members, the tribes already have an incentive to provide the best possible health service to their members. Also, tribes probably cannot afford the luxury of voluntary choice, given the limited funds available, the seriousness of the medical problems, and the small membership base on which the HMO would have to operate.

The concepts of voluntary enrollment and prepayment by subscribers would radically change the present concept of Indian entitlement to federal health care. IHS and Congress have usually considered their obligation to tribes, not to individual Indians. Under any voluntary enrollment approach, the federal money for Indian health services would have to be broken out on a per capita basis. Each tribal member would have to be allocated money for health services. Approaching the federal Indian health relationship on a per capita basis opens all kinds of possibilities. With each Indian perceived as having an individual entitlement, it might increase the dignity with which Indians are treated. On the other hand, it is unclear how Congress would react to a per capita health entitlement. Such an approach also has certain similarities to termination. In most places, there would be no reasonable alternative medical care, and therefore, there could be no voluntary enrollment.

(4) Physicians at Risk. The tribe would be at risk in that it could not overrun the budget allocated to it by IHS. But if the tribe wanted to put the physicians at risk, that is, let them benefit financially if the HMO does its job well, it could no longer use IHS doctors since they are on government salary and could not accept bonuses from the HMO. This would require the tribe to recruit its own doctors which would be both difficult and expensive.

(5) Group Practice and an Enrolled Population. The tribe would be able to retain the same situation it now has under IHS, with doctors on salary practicing in a group and reviewing each others' work. The big problem posed whenever HMO's are considered for Indians is the small size of most tribes. Exept for the Navajo, Cherokee, and the United Sioux there are no tribes with a population that gives an HMO the recommended enrollment of from 25,000 to 40,000 and these tribes could not operate out of a single service center. The cost of an HMO increases

with the addition of more centers or satellite clinics. For this reason many people dismiss the feasibility of HMO's for individual Indian tribes. But this is an oversimplification of a complex issue. One of the reasons an HMO cannot afford to raise its premiums is that higher premiums would make it non-competitive and keep potential subscribers away. Indians are not a sought-after medical population, and there is not likely to be much competition for their money. Whatever system Indian tribes adopt will be expensive if it is to meet comprehensively their needs.

The competition cost factor has little relevance for Indians. Indians have a limited amount of money for health and must stretch it as far as it will go. IHS would also probably operate more efficiently, if it had SU populations of 25,000 to 40,000. One could justifiably argue that IHS cannot work with an enrolled population unit of 1,000 to 6,000. This may be true but it merely states the obvious--that a 1,000-6,000 rural population is not the ideal population unit for health delivery, whatever system used, be it HMO's, IHS, or traditional fee-for-service.

Therefore Indians have two choices: to work cooperatively with their non-Indian neighbors and sacrifice tribal control, or stick with their non-ideal health population unit and sacrifice economic efficiency. Once the latter choice is made, the only relevant question is what system offers the most to the Indians given their small, dispersed population.

For these many reasons it will be very difficult for a tribal health program to jmet the requirements set out in the 1973 HMO Act. The only advantage of doing so is to make the tribe eligible for HMO grants. But those grants are small and are mainly for planning and marketing, not for the delivery of services. This offers Indians less incentive than it would a population presently receiving medical care on a fee-for-service basis.

Conclusions

An HMO is not a magical formula for Indian control of health services. A tribe gains or loses nothing just by calling its health delivery system an HMO. An HMO is nothing more than a series of concepts that have been valuable in the provision of better health services--primarily among an urban population and primarily as an alternative to individual fee-for-service medical care. On the other hand, the HMO model should not be brushed off by Indian tribes as having nothing to contribute. Different aspects of the HMO concept might be attractive to different tribes. Some tribes might want to continue to get their doctors from IHS, others might want to try to recruit them on their own and give them financial

incentives. Tribes might want to set up a guaranteed benefit package, although not necessarily the same as the one required under the Act. Tribes in the same geographical areas might want to join together, perhaps through their Area Health Boards, to pool their resources and to share the fixed costs of certain specialists or equipment just as IHS does through its regional medical centers, or as an HMO does through hiring specialists for its large enrollment population. If a tribe adopts some of the concepts of an HMO, but not all, it might not qualify under the Act. But that should not be a major issue of concern. There are many options for delivery systems available to a tribe that wishes to assert operational control over its health delivery system, and what it is called, be it an HMO, an IHS, or an XYZ, is really irrelevant.

IHS has shown Indians one way of organizing and delivering health services. HMO's have other characteristics that might be usefully incorporated into an Indian health system. In developing their own health delivery system, tribes should have the perogative to adopt and adapt from each of these systems and select a delivery system that is most viable for themselves. This means that the body of knowledge on how to deliver services that HMO's have developed over the years should be made available to Indian tribes to incorporate what is useful and reject what is not. It is recommended that IHS, a tribe, or an Indian organization be granted funds from the 1973 HMO Act to examine the HMO structure and experience, evaluate its relevance to Indians, and distribute the information to Indian tribes that are considering taking over their health delivery system from IHS.

Provisions for Indians should also be written into the new regulations which will be issued pursuant to the HMO Act. The regulations should require that an HMO in an Indian area involve the tribe and IHS in its planning in order to be eligible for grants or loans under the Act.

APPENDIX A

PERSONS INTERVIEWED

1. Indian Health Service Headquarters

Dr. Emery Johnson, Director, Indian Health Service
Henry Chadwick, Deputy Director
Warren Cardwell, Director, Division of Program Formulation
Larry Lovenstein, Assistant Director
Dr. Richard Uhrich, Director, Division of Program Operations
Thelma Domenici, Assistant Director
Dr. Robert Lindsay, Director, Division of Resource Coordination
Dr. James Felsen, Special Assistant to the Director of the Division of Resource Coordination
Jack Casebolt, Director, Office of Planning and Evaluations
Joe Graber, Office of Health Resources
Tim Shea , Office of Evaluations
Jim Mitchell, Office of Contract Health Services
Dr. Lionel deMontigny, Director, Division of Indian Community Development
Mozart Spector, Director, Office of Program Satistics
Eva Preston, Office of Program Statistics
James Weissenborne, Assistant General Counsel, HSA
Perry Sundust, Chairman, National Indian Health Board
" Phoenix Area Health Board
Robert Hunter, Director, NIHB
Fred Deer, Assistant Director, National Indian Health Board

2. Phoenix Area

Dr. Charles S. McCammon, Area Director
Sam DeCorse, EEO and Training Officer
S.W. Kurth, Chief, Contract Branch
H.F. Palone, Chief Financial Management Branch
Juana Gover, Office of Indian Community Development
Elmer Lidstone, Chief, Office of Program Planning
Dr. Thomas Bittker, Office of Mental Health
Dr. Carl Hammerschlag, Office of Mental Health
Francis McKinley, Director, NITRC
Herbert Clah, President, AMERIND, Inc.
Nellie Clah, Editor, The Concerned Indian
Mike Anderson, Assistant Editor, The Concerned Indian
Franklin LaFave, Consultant, AIC
Harlan Bohnie, Consultant, AIC

Phoenix Area (Cont'd)

Kent Ware II, Attorney, EEOC
Rodney Lewis, Attorney
LaVonne Three Stars, Counselor, Phoenix Indian School
Richardo Martinez, Bibliographer
Thomas Banyayac, Medicine Man
Bernice Horace, Consumer
Bill Tiger, Consumer
Tennyson Welborne, Student

White Mountain Apache Tribe

Jack Russell, Service Unit Director, Whiteriver Service Unit
Bill Baker, Administrative Officer
Dr. David Baugh, Clinical Director
George Romance, Social Services
Lester Oliver, Health Educationer
Fritz Tenijieth, Chairman, White Mountain Apache, Health Education and Welfare Committee
Wesley Bonito, Tribal Council Member, White Mountain Apache Tribe

Hopi Tribe

Abbott Sequaquaptewa, Chairman of the Hopi Tribe
Samuel Dashee, Vice Chairman of the Hopi Tribe
Art Acoya (Laguna), Executive Officer, Keams Canyon Service Unit
Dr. John Citron, Keams Canyon Service Unit
Ethaleen Sekakuku, Director, Health and Home Care
Virginia Taylor, Assistant Director, Home Health Care Program
Homer Cooyama, Hopi Medicine Man

3. Tucson Area

Dr. Stewart Rabeau, Area Director
Larry Byrd, Systems Analysis
Dr. Robert Smith, Industrial Engineer
Charles Ericson, Staff

Desert Willow Training Center

Robert McKay, Director
James Lawler, Assistant Director
Dr. Nadine Rund, Director, Management Training Section
Bud Bunch, Training Officer
Jim Justine, Training Officer
Irving Schlafman, Consultant and Former Training Officer
Ralph Meyer, Director, CHR Training Program

Desert Willow Training Center (Cont'd)

Bonnie Haggins, CHR Training Officer
Jack Kreineyer, CHR Training Officer
Gordon Denipah, Jr., Staff

Sells (Papago) Service Unit

Dr. Rice Leach, Service Unit Director
Dr. Jon Reed, Physician
Dr. Robert Bagge, Physician
Rosemary Lopez, Community Health Medic

Executive Health Staff, Papago Tribe

Cecil Williams, Chairman and Director, Papago Mental Health Program
Lorna Patrucio, Vice-Chairman, EHS and Director, Papago Nutrition Program
Ralph Antone, EHS and Director, Papago CHR Program
Hank Atha, EHS, Director, Papago CAP
Irene Wallace, EHS and Director Papago Disease Control Program
Wilfred Mandoza, EHS and Director Papago Alcoholism Program
Tillie Juan, EHS and Administrative Assistant to the Papago CAP Programs
Connie Pichecko, IHS, on assignment to the EHS
Terri Coyne, Staff, Papago Nutrition Program

4. United Southeastern Tribes (USET)

Eugene Begay, Director, Mental Health, USET
Peggy Barnett, Director of Training, USET
Mars Rochelle, Alcoholism Workshop Coordinator, USET
Gerald L. Webster, Health Careers Counselor, USET
Gladys J. Bratcher, Acting Associate Deputy EEO Officer, IHS
James C. Meredith, Acting Program Director, IHS
Jo Dan Osceola, Service Unit Director, Seminole Service Unit
Frank Henry, Service Unit Director, Choctaw Service Unit
Burr Webster, Director, Health Department, Choctaw Service Uni
Charles Halseth, Administrator, IHS
Elaine Delafazio, Administrative Assistant, IHS

5. Navajo Area

Dr. George Bock, Area Director, Navajo Area
Dr. Taylor McKenzie, SUD, Shiprock
Harold Lope, Director of the CHR Program, Navajo Tribe

Navajo Area (Cont'd)

Ben Hogue, Chairman of the Area Health Board, Chairman of the Tribal, Health, Welfare and Alcoholism Committee Navajo Tribe
Jerry Bathke, Executive Director, Navajo Health Authority (NHA)
Carl Gorman, Director, Native Healing Sciences, NHA
Larry Kallon, Director, Office of Program Planning, Evaluation, NHA
Jack Jackson, Director of the Office of Student Affairs, NHA (AHAC)
Mike Lincoln, Counselor, Office of Student Affairs, NHA
Tom Stewart, AHEC, NHA
Ray Reed, Intern, NHA

6. Portland Area

Stan Stitt, DDS, Area Director, Portland Area Office
John Cordoya, Budget Officer, Portland Area Office
Ashley Foster, Ph. D., Planning and Evaluation Office, Portland Area Office
David Fruit, Contract Officer, Portland Area Office
John Halfmoon, Human Resources Development Specialist, Portland Area Office
Joe Long, EEO Officer, Portland Area Office
Billie von Fumetti, Mental Health Nurse, Portland Area Office
Julie A. Johnson, Director, Seattle Indian Health Center
Aggie Marek, Family Services, Seattle Indian Health Center
Luana L. Reyes, Director, Seattle Indian Health Board, Inc.
Jill Newby, Seattle Indian Health Board, Inc.
Lori Takeuchi, Coordinator of Counselors, Seattle Indian Health Board, Inc.
Joe Cloquet, Health Administrator of Small Tribes of Western Washington (STOWW), Washington
Bill Jeffries, Governor's Special Assistant for Indian Affairs, Tumwater, Washington

7. Billings Area

Stan Rogers, Acting Area Director, Billings
Frances Dixon, Chief, Office of Community Health Services
Dr. Al Dohner, Medical Services Branch, Billings Area Office.
Dona Gudgell, Office of Equal Employment Opportunity, Billings Area Office
Jay Harwood, Tribal Affairs Officer, Billings Area Office
Florence Jones, Office of Equal Employment Opportunity, Billings Area Office
Harvey Lich, Office of Program Planning and Evaluation, Billings Area Office
Dr. Clayton McCracken, Office of Special Health Programs, Billings Area Office
Bart Proper, Chief, Office of Patient Care Services, Billings Area Office

Billings Area (Cont'd)

Sandra Walks, Secretary, Billings Area Office
Jerry Zitur, Contract Health Services Branch, Billings Area Office
Russ Miller, Service Unit Director, Northern Cheyenne SU, Lame Deer, Montana
Bob Bailey, Director, Head Start, Northern Cheyenne, Lame Deer, Montana
Mrs. Bailey, Acting Director, Community Health Representative Northern Cheyenne tribe, Lame Deer, Montana
Shirley P. Meyers, CHR, Northern Cheyenne SU, Lame Deer, Montana
Ada White, Director, Community Health Representatives, Member, Crow Health Committee, Area, and National Health Boards, Crow Agency, Montana
George and Olive Bad Bear, former IHS employees, Crow Agency, Montana
Julia Not Afraid, Lodge Grass, Montana
Angela Russell, Crow Health Committee, Lodge Grass, Montana
Marjorie Winans, Tribal Judge, Crow Agency, Montana
Ernie Big Horn, Indian Studies, Rocky Mountain College, Billings
Wyman J. McDonald, Executive Director, Tri-State Tribes, Inc., Indian Community Action Program, Training and Technical Assistance, Billings
Joy Toyneta, Nutritionist, Wyola, Montana

8. National Organizations, Congressional Staff, Others

Richard K. Barlow, Staff Attorney, Health Law Project, University of Pennsylvania Law School
Nick Cavarocchi, Georgetown University Community Health Plan
Joyce Dubow, Corporate Executive, Georgetown University Community Health Plan
Robert A. Fisher, Assistant Secretary, Division of Parish Development and Missions, National Ministries, American Baptist Churches, USA, Valley Forge, Pennsylvania
Hal Gross, Director of Indian Legal Information Development Services, Washington, D. C.
Bob Moore, Executive Director, American Indian Commission on Alcoholism and Drug Abuse, Arvada Colorado
Jerry Muskrat, Staff Attorney, U. S. Commission on Civil Rights
Robert C. Sakiestewa, Jr., Human Resource Development Specialist, Albuquerque Area Office, IHS, Albuquerque, New Mexico
Harris Sherman, Jr., of law firm of Sherman and Sherman, Denver, Colorado
Charles Trimble, Director, National Congress of American Indians, Washington, D. C.
Tillie Walker, Director, United Scholarship Service
Rose Robinson, American Indian Press
Bob Alvarez, Staff, Sen. James Abourezk, (S.D.)
Forrest Gerard, Staff Person, Senate Interior and Insular Affairs Committee

APPENDIX B

Appendix B

BIBLIOGRAPHY

I. INDIAN INVOLVEMENT

A. TRIBES

Fort Apache Indian Reservation, Arizona. Meeting with HEW, "Meeting Concerning Project Apache," August 27, 1973.

Tribal Council of the White Mountain Apache Tribe. "Resolution of the White Mountain Apache Tribe of the Fort Apache Indian Reservation." Resolution No. 73-159. Sept. 25, 1973.

Oklahoma City Area Indian Health Service, Oklahoma City, Oklahoma. Contract No. HSM 75-70D-101. Contract to Eastern Band of Cherokee Indians, Cherokee, N.C. for "Services of Community Health Representatives." June 30, 1970.

Crowe, John A., Principal Chief of the Eastern Band of Cherokee Indians. Letter to Jim Meredith, Indian Health Service. Enclosure: Revised proposal for project: "Eastern Band of Cherokee Indians evaluation of Health Service to the Cherokee Indian Reservation." Cherokee, N.C., May 1, 1973.

Crow Community Health Representatives, Ada White, Supervisor. "Report on the Crow Consumer Health Study." Crow Indian Reservation, Montana. 1971.

Crow CHR Office, Ada White, CHR Supervisor. "CHR Survey of the Crow Reservation." Crow Reservation, Montana, 1971.

MacDonald, Peter. "Testimony of Peter MacDonald, Chairman, Navajo Nation, on Title I of S.1017, the Indian Self-Determination Act before Senate Sub-Committee on Indian Affairs of the Senate Interior Committee, June, 1973." June 13, 1973.

Mississippi Band of Choctaw Indians. "Accelerated Progress through Self-Determination--First Annual Report of the Choctaw Self-Determination Project--July 1, 1971-July 31, 1972." Philadelphia, Miss., 1972.

Mississippi Band of Choctaw Indians. "Evaluation of the Choctaw Service Unit." Submitted to Sarasota Program Office, IHS. Philadelphia, Miss., Sept. 12, 1972.

Gila River Indian Community. "Constitution and Bylaws of the Gila River Indian Community, Arizona." Approved March 17, 1960. Washington, D. C.: Government Printing Office, 1960.

"Area Health Education Center of the Navajo Health Authority to Establish the Navajo Center for Health Professions Education." Printed October, 1973 following award of Contract No. 724896 to the University of New Mexico, 1968.

Navajo Health Authority. "Plan of Operation." Exhibit "A". Window Rock, Arizona. 1973.

Navajo Health Authority. "Position Paper and Statement of the Navajo Health Authority." Window Rock, Arizona. 1973.

Navajo Area Indian Health Service, Public Health Service, Department of Health, Education, and Welfare. Contract for "Navajo Health Authority Management Program." Window Rock, Arizona, effective July 1, 1973.

Wiese, William H., M.D., Project Director, University of New Mexico, and Stewart, Thos. J., Interim Program Director, Navajo Health Authority. "First Annual Report--The University of New Mexico School of Medicine Area Health Center--October 1972 to September 1973."

Ad Hoc Committee for Papago Health Organizations and Related Activities. "Summary of Activities of Ad Hoc Committee for Papago Health Organizations aznd Related Activities."

Antone, R., Erickson, C., Esquivel, G. et al. "Report to the Papago Tribal Chairman of the Ad Hoc Committee for Papago Health Organization and Related Activities." May 15, 1972.

Papago Council, Augustine Lopez, Chairman, Betsy J. Norris, Secretary. "Resolution of the Papago Council."

Papago Tribe. "A Suggested Protocol for Evaluation of Health Services--IHS and Tribal Health Program Systems Center, Tucson, Arizona. April 20, 1971.

Segundo, Thomas A., Chairman of the Papago Council. Letter to Charles Erickson, Health Program Systems Center, Tucson Arizona. April 20, 1971.

Thinking Session--Health on Papago. Tucson, Arizona, September 28 and 29, 1972.

Alligator Times. Vol. II, No. 6-8, September-November, 1973. Florida: Seminole Tribe of Florida.

United Sioux Tribes of South Dakota. "Evaluation Service Contract Proposal." Pierre, South Dakota, May 1, 1973.

Arnold and Company, Certified Public Accountants. "United Southeastern Tribes, Inc.--Sarasota, Florida, Audited Financial Statements, May 31, 1973."

Cournoyer, Ron. Memorandum to Executive Director, United Southeastern Tribes, Inc. Subject: "Promotion of Linda Owens." Sarasota, Florida. January 26, 1973.

Goetting, R.C., Consultant to United Southeastern Tribes, Inc. "Operating Procedures Manual (Preliminary Draft)."

"Negotiated Contract." Contract No. HSM 110-73-369, issued by Health Services and Mental Health Administration to United Southeastern Tribes, Inc. Effective April 16, 1973.

Saunooke, Osley B., Executive Director, United Southeastern Tribes, Inc. Letter to Emery A. Johnson, Director, Indian Health Service. April 25, 1973. Enclosure: Memorandum for the Record. Subject: "Joint Meeting--December 4 and 5, 1972, IHS Headquarters--Rockville, Maryland."

USET Area Office. "Affirmative Action Plan for Equal Employment Opportunity FY 1974." Sarasota, Florida: USET Area Office, IHS.

United Southeastern Tribes, Inc. "Contractor's Proposal." Contract No. No. 1 MB 34113 (P).

United Southeastern Tribes. "Policy Statement of the United Southeastern Tribes Regarding New Federal Legislation Affecting the Indian People." Washington, D.C.: Government Printing Office.

United Southeastern Tribes, Inc. "Staff Meeting." September 17, 1973.

United Southeastern Tribes, Inc. "United Southeastern Tribes, Inc." Sarasota, Florida.

United Southeastern Tribes, Inc. "USET Management of Sarasota IHS Program Office," and "Brief Description of Proposed Management Package."

United Southeastern Tribes, Inc. "USET Proposal to Assume Management Control of Indian Health Service Program Area." Sarasota, Florida. November 24, 1972.

C. PROPOSALS TO IHS ON TRIBAL EVALUATIONS BY:

Association of American Indian Social Workers. "Evaluation of Mental Health Service." Contract No. HSM-16(3).

Fort Belknap Indian Community Council. "Evaluation Project Proposal--Health Program Evaluation: Impact Study of PL 86-121 Projects on the Fort Belknap Indian Reservation." May 17, 1973.

Northwest Portland Area Indian Health Board.

Oklahoma City Area Indian Health Service Advisory Board. Tribal Evaluation Organization. "Evaluation Proposal: Oklahoma City Area IHS Project for Program Evaluation and Improved Indian Involvement." May 29, 1973.

Papago Health Board.

United Sioux Tribes.

National Indian Health Board. "Progress Report on the Evaluation of the Indian Health Service Health Delivery System--Phase I--Identification of Specific Problems and Issues Based on Indian Consumer Opinion." Denver, Colorado. July, 1973.

D. NATIONAL INDIAN HEALTH BOARD COMMUNITY MEETING REPORTS--CONDUCTED UNDER EVALUATION CONTRACT

Salt River Pima-Maricopa Indian Community, Scottsdale, Arizona. May 14, 1973.

Saginaw Chippewa Indian Tribe, June 4, 1973.

Creek Indian Community, Okmulogee, Oklahoma. June 5, 1973.

Colorado River Indian Tribes, Parker, Arizona. June 8, 1973. Attachments:

a. Fisher, Adrian, Sr., Chairman Colorado River Indian Tribes. Letter re Resolution R-7-70 of January 23, 1970, asking for "Construction of a modern up-to-date and adequate Indian hospital facility at Colorado River Indian Reservation."
b. Resolution R-7-70 of January 23, 1970, signed by Adrian Fisher, Sr., Chairman, and Marjorie Scott, Secretary, asking for an Indian facility in the Parker area.
c. Summary Sheets PHS Hospital, Parker, Arizona. July 22, 1970.
d. Gonzales, Antone, Sr., Chairman of Colorado River Tribes. Letter to Charles McGammon, Phoenix

Zunigha, Wayne V., Executive Director, United Southeastern Tribes, Inc. Letter to Dr. Emery Johnson, Director, Indian Health Service. January 10, 1972. Enclosure: "Proposed Detail of Ronald L. Cournoyer to the United Southeastern Tribes, Inc.," Budget proposal of twelve months for the Health Program Development Project for USET. January 1, 1972.

B. AREA HEALTH BOARDS

"Billings Area Program Priorities--For Area Health Advisory Board Meeting April 3-5, 1973," Fiscal Year 1974.

"Operating Guidelines, Billings Area Indian Health Advisory Board."

"California Rural Indian Health Board," Project News, Winter 1971/72.

Phoenix Area Indian Health Board. "Constitution of the Phoenix Area Indian Health Board." May 8, 1972.

"Article I--Description and Scope of Work." From Contract with the N.W. Portland Area Indian Health Board.

Health Services and Mental Health Administration, Portland Area IHS, Portland, Oregon. Contract No. HSM-79-73-406 to N.W. Portland Area Indian Health Board, Portland, Oregon, for a "Communith Health Program." May 31, 1973.

Health Services and Mental Health Administration, Portland Area IHS, Portland, Oregon. Contract No. 79-73-412 to N.W. Portland Area Indian Health Board, Portland, Oregon, for "Evaluation Services." June 27, 1973.

Negotiated Contract, Contract No. HSM-79-73-406. N.W. Portland Area Indian Health Board, Portland, Oregon, Contractor. May 31, 1973.

Negotiated Contract, Contract No. HSM-79-73-407. N.W. Portland Area Indian Health Board, Portland, Oregon, Contractor. May 31, 1973.

Tribal Evaluation Organization. Northwest Portland Area Indian Health Board. 1973.

Indian Health Service Area Office, recommending Lou Weil as Service Unit Director, June 7, 1973.

e. Resolution R-27-73 to "Recommend the establishment of an Administrative Director of the Colorado River Public Health Service Hospital." Signed by Antone Gonzales, Sr., Chairman, and Sue N. L. Murdock.

Stockbridge Munsee Reservation, Bowler, Wisconsin, June 12, 1973.

Turtle Mountain, North Dakota.

Oneida Tribe of Indians in Wisconsin, Oneida, Wisconsin. June 13, 1973.

Seminole Tribe of Florida, Hollywood, Florida. June 19, 1973.

Reno-Sparks Indian Community, Nevada. June 21, 1973.

Wind River Indian Reservation, Arapahoe, Wyoming. June 21, 1973.

Kamiah Community Center, Washington. June 26, 1973.

Nez Perce Tribe of Idaho, June 27, 1973.

Fort Totten Indian Reservation, North Dakota. June 27 and 28, 1973.

E. COMMUNITY HEALTH REPRESENTATIVES

LaPointe, Elmer C., Acting Area CHR Coordinator, Aberdeen Area IHS. Letter to Webster Two Hawk, President, Rosebud Sioux Tribe, Rosebud, South Dakota. January 29, 1973. Enclosures

a. Aberdeen Area IHS, Public Health Service, Department of Health, Education, and Welfare, Contract No. HSNSO-73-236, providing for the services of Community Health Representatives for the Rosebud Sioux Tribe. Signed June 20, 1972.
b. "Rosebud Sioux Tribe Community Health Representative Program Proposal Fiscal Year 1973."
c. "Rosebud Sioux Tribe Community Health Representative Program--Personnel Policy and Procedures."
d. "Rosebud Sioux Tribe Community Health Representative Program--Job Description."
e. "Rosebud Sioux Tribe Community Health Representative Program--Annual Budget."
f. Leo Cordier, Secretary of Rosebud Sioux Tribe, Rosebud, South Dakota. Memorandum to Community Health Representative Program, Public Health Service, Rosebud, Public Health Service, Aberdeen South Dakota. Subject: "Actions on the CHR Program." May 2, 1972.

National Indian Training and Research Center. "Community Health and Education Evaluation." Tempe, Arizona, May 15, 1970.

National Indian Training and Research Center. "Final Summary Report--Community Health Representative Study Phase I." Tempe, Arizona.

Office of Program Development, Indian Health Service, Public Health Service, Health Services and Mental Health Administration, USDHEW "Community Health Representative--A Changing Philosophy of Indian Involvement." Washington, D.C.: Government Printing Office.

Sampson, Paul and Gunby, Phil. "Health Representative: A new tribal role," JAMA, Vol. 218, No. 5 (November 1, 1971).

Sampson, Paul and Gunby, Phil. "'Substitute doctors' are on the way to aid IHS," JAMA, Vol. 218, No. 5 (November 1, 1971).

F. Self-Determination and Buy Indian Act

Bruce, Louis R., Commissioner of Indian Affairs. Memorandum to All Area Directors; LADC Property and Supply Officer, Albuquerque, New Mexico, et al. Subject: "Comptroller General's Decision B-170427--Protest of award of contract negotiated under 'Buy Indian Act.'" Enclosures. February 11, 1971.

Bruce, Louis R., Commissioner of Indian Affairs. Memorandum to Superintendents, Cherokee, Miccosukee, Choctaw and Seminole; All Area Directors; All Superintendents et al. Subject: "Moratorium on Contracting for Construction under the Buy Indian Act Cancelled." April 27, 1971.

Bruce, Louis R., Commissioner of Indian Affairs. Memorandum to Area Directors--Central Office Jurisdiction Staff. Subject: "Policy statement--Buy Indian Act Contracting, Goals and Procedures." Washington, D.C.: Bureau of Indian Affairs, Department of the Interior.

Buzzell, Harold O., Administrator, Health Services and Mental Health Administration, Public Health Service, Department of Health, Education, and Welfare. Memorandum to Director, Office of Indian Affairs, OSC/P. Subject: "S. 1017--Indian Self-Determination and Educational Reform Act of 1973." May 18, 1973.

Solicitor. Memorandum to Commissioner of Indian Affairs. Subject: "Negotiability of Construction Contract under the 'Buy Indian' Act of June 25, 1910." April 27, 1971.

Gottesman, William B. "The Quest for Indian Self-Determination: A Study of the Participatory Programs of the Indian Health Service." Unpublished Master's thesis, Graduate School of Public and International Affairs, University of Pittsburgh, 1970.

"Indian Involvement Programs," Bureau of Indian Affairs Manual Washington, D.C.: Government Printing Office, May 21, 1971.

MacDonald, Peter. Letter to Sen. Henry Jackson re S. 1017, "The Indian Self-Determination Act." August 15, 1973.

MacDonald, Peter. Letter to Marvin Franklin, Secretary of Indian Affairs, Department of Labor, Washington, D.C. re Self-Determination. August 17, 1973.

MacDonald, Peter. Letter to Anthony P. Lincoln, Area Director, Navajo Area Office, Window Rock, Arixona, re Self-Determination. August 17, 1973.

MacDonald, Peter. Letter to Secretary Peter Brennan, Department of Labor, Washington, D.C., re Self-Determination. August 21, 1973.

Memorandum Report. Project Outreach, an assessment of tribal attitudes and appraisal of the extent of Tribal Council experience in administering federal assistance programs. Prepared for NCIO. April 28, 1970.

National Indian Training and Research Center, under contract with the Oklahoma Area Office, IHS, Oklahoma City, Oklahoma. "NITRC Program for Orientation and Training of Tribal Leaders and Members in the Federal Personnel System." Tempe, Arizona, September 24-28, 1973.

U.S. Congress. House. H.R. 6103, Introduced by Rep. Meeds. 93rd Congress, 1st session, March 26, 1973.

U.S. Congress. House. H. Con. Res. 158, submitted by Rep. Hastings. 93rd Congress, 1st session, March 20, 1973.

U.S. Congress. Senate. Subcommittee on Indian Affairs of the Committee on Interior and Insular Affairs. Hearings on S. 1017 and Related Bills. 93rd Congress, 1st session, June 1 and 4, 1973.

U.S. Congress. Senate. S. 1017, introduced by Sens. Jackson and Abourezk. 93rd Congress, 1st session, February 26, 1973.

U.S. Congress. Senate. S.J. Res. 133 submitted by Sen. Abourezk. 93rd Congress, 1st session, July 16, 1973.

II. INDIAN HEALTH SERVICE

A. HEADQUARTERS

Acting Director, Health Program Systems Center, IHS, Tucson. Memorandum to David C. Crockett, Program Planning Officer, IHS, Rockville, Maryland. Subject: "Fiscal Year '71 Evaluation Projects." November 3, 1971.

Director, Office of Health Resources, IHS. Memorandum. Subject: "Area and Program Focal Points Named as Counterparts for Office of Health Resources, Headquarters." June 8, 1973.

Edelman, Sidney, Office of the General Counsel, Public Health Division. "Indian Health--Criteria of Eligibility." May 7, 1956.

Edelman, Sidney, Office of the General Counsel, Office of the Secretary, HEW. Memorandum to Emery A. Johnson, M.D. Subject: "Indian Health--Use of established blood quantum to determine eligibility for services." November 11, 1971.

Hallinger, Robert T. and Harrison, Gladys. "Indian health--Questions relating to eligibility." IHS. March 17, 1955.

Harrison, Gladys, Assistant General Counsel, HEW. "Legal Framework of Health Services for Indians." Remarks at Conference of Medical Officers, Division of Indian Health, May 17, 1956.

Indian Health Service. "Federal Government--American Indian Relationship: Health--A Strategy."

Indian Health Service. "Five Year Evaluation Strategy." 1973.

Indian Health Service. "Forward Planning Document." March, 1973 and 1974.

Indian Health Service. "Operational Planning System (OPS), 1973, 1974."

Indian Health Service. "Plan for Medical Facilities Needed for Indian Health Services." 1958.

Indian Health Service. "Program Report and Plan--Indian Health Service--Fiscal Years 1971-1975." May, 1969.

Indian Health Service Health Program Systems Center. "Current and Completed Projects July, 1971." Tucson, Arizona. July, 1971.

Johnson, Emery A., Assistant Surgeon General, Director of IHS. Memorandum to the Secretary of HEW. Subject: "Restructuring the Secretary's Advisory Committee on Indian Health--Action Memorandum." Prepared by Cardwell, X32546, March 21, 1972.

Johnson, Emery A., Director of IHS. Memorandum. Subject: "Role of Indian Health Service Regional Assignees." January 26, 1973.

"Minutes of the 6th BIA-IHS Policy Coordination Meeting," October 11, 1967.

"Minutes of the 10th BIA-IHS Policy Coordination Meeting," December 11, 1969.

Office of Program Planning and Evaluation, IHS. "Report of the Data Requirements and Guidelines Review Workshop--Service Unit Planning." Meeting at Desert Willow Training Center, Tucson, Arizona. March 2-8, 1969.

Office of Research and Development, IHS. "Indian Health Service Office of Research and Development." Washington, D.C.: Government Printing Office, 1973.

Office of Research and Development, IHS. "An Outline of the Proposed Quality Assurance Program for the Sells Service Unit--An Experimental Medical Care Review Organization." Tucson, Arizona: ORD, April, 1973.

Office of Research and Development, IHS. "The IHS Health Information System--Summary Description--4 January, 1972." Washington, D.C.: Government Printing Office.

Office of the Secretary, USDHEW. "Indian Poverty and Indian Health." Reprinted, March 1969.

PAC Subcommittee on End the Draft Alternatives. "Immediate Proposed Programs to be Implemented to Assure an Adequate Supply of Physicians for IHS for FY 1974." 1973.

Public Health Service, USDHEW. "The Indian Health Program of the U.S. Public Health Service." PHS Publication No. 1026, revised 1966 and 1969. Washington, D.C., Government Printing Office, 1966 and 1969.

Public Health Service Indian Health Center. "HPSC Current Project Summaries and Published Monograph Abstracts 1967."

"To the First Americans--Annual Reports on the Indian Health Program of the U.S. Public Health Service." PHS Publication No. 1580, revised 1967, 1968, 1969. Washington, D.C.: Government Printing Office, 1967, 1968, 1969.

B. AREAS

Billings Area IHS. "Operating Plan Fiscal Years 1973-1974--Billings Area." Billings, Montana.

Billings Area IHS. "Operating Plan, Fiscal Year 1974--Contract Health Services Policy." Billings, Montana.

Director, Billings Area IHS. Memorandum to Director, IHS, Rockville, Maryland. Subject: "Monthly Narrative Report, April 1973." May 10, 1973.

Acting Director, Billings Area IHS. Memorandum to Director IHS, Rockville, Maryland. Subject: "Monthly Narrative Report, May 1973." June 19, 1973.

Billings Area Indian Health Advisory Board Members and Service Unit Directors. "Billings Area--Area Unmet Health Needs." 1972.

Billings Area Office, IHS. "Budgetary Needs in Support of Fiscal Year 1974--IHS Budget." November 30, 1972.

Health Services and Mental Health Administration, DHEW. "Addendum to 'Information and Data in Support of Fiscal Year 1974 IHS Budget'--Billings Area." December 18, 1972.

Lich, Harvey, Chief, Area Office of Program, Planning and Evaluation. "Billings Area Fiscal Year 1974 Objectives and Plans." May 10, 1973.

Navajo Area Office, IHS. "Program Plan F.Y. 1974."

"Navajo Area Indian Health Service, Health Problems, Health Programs, Health Program Deficiencies and Justification for Increased Fiscal Year 1972 Resources." (Prepared at the request of Navajo Tribe), 1972.

Public Health Service, USDHEW. "Orientation to Health on the Navajo Indian Reservation." Revised May, 1960.

Office of Program Planning, Phoenix Area IHS. "Phoenix Area, IHS Fiscal Year 1974--Phoenix Area Emphasis Plans and Phoenix Service Unit Emphasis Plans--Tabulation." May 17, 1973.

Office of Program Planning, Phoenix Area IHS. "Phoenix Area Emphasis Plans--1st Quarter Fiscal Year 1974--Status Report--July-August-September 1973." October 11, 1973.

Phoenix Area IHS. "Program Package." Phoenix, Arizona. 1973.

Director, Phoenix IHS. Memorandum to Director, Division of Program Operations, IHS. Subject: "Comments on GAO Progress and Problems in Providing Selected Health Services to Indians." July 27, 1973.

Mental Health and Social Services Branches, Office of Professional Program Development and Consultation, Portland Area Indian Health Service. "Emphasis Plan, Fiscal Year 1974."

Office of Program Planning and Evaluation, Portland Area IHS. "Portland Area Indian Health Service--Emphasis Plans Fiscal Year 1974." April, 1973.

Portland Area Office, IHS. "Portland Area Program Plan Fiscal Year 1973." Portland, Oregon. December, 1972.

"Budget Cycle for the Portland Area Office."

Budget Officer, Portland Area Office. Memorandum. Subject: "Preparation of 1974 Budget." June 1, 1973.

Equal Employment Officer, Office of the Area Director, Portland Area IHS. Memorandum. Subject: "EEO Affirmative Action Plan for Portland Area IHS." May 11, 1973.

Portland Area IHS. "Affirmative Action Plan for Equal Employment Opportunity, Fiscal Year 1974."

Portland Area Indian Health Service. "Health Services Information--A Pamphlet for Advisors of Indian Students."

Portland Area Indian Health Service. "Health Services Information for Students from Federally Recognized Tribes."

Portland Area Office. "Contract Health Services in the Portland Area."

C. SERVICE UNIT PROGRAM AND OPERATING PLANS

Alaska Area, Mt. Edgecumbe Service Operating Plan, F.Y. 1974.

Billings Area, Northern Cheyenne Reservation Operating Plan, F.Y. 1971.

Portland Area, Taholah Service Unit Program Plan, F.Y. 1973.

Phoenix Area, Program Plans, Fiscal Year 1974. Service Units: Colorado River, Fort Yuma, Keams, Owyhee, Phoenix, Reno Field Office, Sacaton, San Carlos, Schurz, Uintah, Ouray, White River.

III. CONGRESSIONAL AND OTHER FEDERAL DOCUMENTS

A. CONGRESS

U.S. Congress. House. Subcommittee on Department of the Interior and Related Agencies of the Committee on Appropriations. Hearings on Department of the Interior and Related Agencies Appropriations for 1974, Part 4. 93rd Cong., 1st sess., 1973.

U.S. Congress. House. Subcommittee on Department of the Interior and Related Agencies of the Committee on Appropriations. Hearings on Department of the Interior and Related Agencies Appropriations for 1974, Part 6. 93rd Cong., 1st sess., 1973.

U.S. Congress. Senate. Committee on Appropriations. Hearings on Department of the Interior and Related Agencies Appropriations. Parts 1-4. 92nd Cong., 2nd sess., 1972.

U.S. Congress. Senate. Committee on Appropriations. Hearings on H.R. 8917, Department of the Interior and Related Agencies Appropriations, Parts 1-4. 93rd Cong., 1st sess., 1973.

Congressional Record. 93rd Cong., 1st sess., Vol. 119, No.69, May 8, 1973.

U.S. Congress. House. Subcommittee on Indian Affairs of the Committee on Interior and Insular Affairs. Hearings on a Review of the Indian Health Program. 88th Cong., 1st sess., May 23, 1963.

U.S. Congress. House. Report No. 870 (to accompany H.R. 303); Transferring the Maintenance and Operation of Hospital and Health Facilities for Indians to the Public Health Service." Submitted by Rep. Miller of Nebraska from the Committee on Interior and Insular Affairs. 83rd Cong., 1st sess., July 17, 1953.

U.S. Congress. Senate. Senate Report No. 310; Survey of Conditions Among the Indians of the United States. 79th Cong., June 11, 1943.

U.S. Congress. Senate. S. 3385 and Report No. 1592 and Amendments. Submitted by Mr. Watkins. Calendar No. 1604. 83rd Cong., 2nd sess., June 11, 1954.

U.S. Congress. Senate. S. 2241, introduced by Sens. Bible, Burdick, Gravel, et al. 91st Cong., 1st sess., May 26, 1969.

U.S. Congress. Senate. S. 1017, re Indian Self-Determination." 93rd Cong., 1st sess., April 21, 1973.

The Budget of the United States Government--Fiscal Year 1975--Appendix. Washington, D.C.: Government Printing Office, 1974.

Comptroller General of the United States. "Report to the Congress of the United States--Medical Services Furnished without Charge to Individuals Financially Able to Pay and Inadequate Rents for Employee Housing--Indian Health Program--Public Health Service--Department of Health, Education, and Welfare." Washington, D.C.: U.S. General Accounting Office, June, 1963.

Comptroller General of the U.S. "Report to Congress--Need for Improved Practices for Obtaining Equitable Contributions toward the Cost of Constructing Sanitation Facilities for Indians--HSMHA, HEW." April 10, 1970.

Comptroller General of the U.S. "Report to the Congress--Study of Health Facilities Contruction Costs." Washington, D.C.: U.S. General Accounting Office, 1972.

B. EXECUTIVE

Nixon, Richard, Former President, U.S. "Message from the President of the United States Transmitting Recommendations for Indian Policy." H.R. Doc. No. 91-363, 91st Cong., 2nd sess., August 8, 1970.

Carlucci, Frank, Under-Secretary of Department of Health, Education, and Welfare. "Statement before the Committee on Interior and Insular Affairs--Subcommittee on Indian Affairs--U.S. Senate." Washington, D.C.: DHEW, June 1, 1973.

Dolan, Dorothea L., Special Assistant for Rural Mental Health. "Community Mental Health Center Services to American Indians." Chevy Chase, Maryland: NIMH, August, 1970.

Johnson, Emery, Director, IHS. Memorandum to George Clark, Director, Office of Indian Affairs. Subject: "Information on Indian Health Service Role in Implementation of Various Health Measures Passed by the 92nd Congress." May 2, 1973.

Office of the Assistant Secretary (Planning and Evaluation), USDHEW. Program Analysis--Human Investment Programs--Delivery of Health Services for the Poor--December, 1967. Washington, D.C.: Government Printing Office, 1968.

Poole, Jerry W., Deputy Assistant Secretary for Congressional Liaison. Memorandum to Creed C. Black, Assistant Secretary for Legislation. Subject: "Sen. Bellmon Suggestion on PHS Indian Hospitals." Washington, D.C., May 5, 1969. Enclosures:
a. "Brief Statement on Sen. Bellmon's Suggestion to Close PHS Indian Hospitals"
b. "Program Data--Indian Health Service"

Weinberger, Caspar W., Secretary of HEW. "Remarks by The Honorable Caspar W. Weinberger Secretary of HEW." Before the National Congress of American Indians, Tulsa, Oklahoma, October 30, 1973. Washington, D.C.: HEW.

Wilson, Vernon, M.D., Administrator, Health Services and Mental Health Administration. Memorandum to the Secretary of HEW. Subject: "Community Mental Health Center Funding Mechanisms and Community Mental Health Center Services to American Indians--Information Memorandum." Washington, D.C., November 17, 1971.

Wilson, Vernon, M.D., Administrator, Health Services and Mental Health Administration. Memorandum to the Secretary of HEW. Subject: "Community Mental Health Center Funding Mechanisms and Community Mental Health Center Services to American Indians--Progress Report following Information Memorandum dated November 17, 1971--Information Memorandum." Prepared by Stockdill, NIMH, February 4, 1972, X33275 and Sweeter, IHS, January 27, 1972, X34243. Washington, D.C., February, 1972.

U.S. Commission on Civil Rights. "Socio-Economic Profile of American Indians in Arizona and New Mexico." Staff Report No. 1, Albuquerque/Phoenix Hearings. November, 1972.

U.S. Commission on Civil Rights. "The Southwest Indian Report." Washington, D.C." Government Printing Office, May, 1973.

U.S. Commission on Civil Rights. Transcript of Proceedings, Albuquerque, New Mexico, November 14-15, 1972. Washington, D.C.: Ace-Federal Reporters, Inc., Official Reporters.

IV. TRAINING AND STAFFING

Association of American Indian Physicians. "Health Career Recruitment Program for American Indian Students."

Blue Spruce, George Jr., DDS, MPH. "Help Wanted: Indian Health Professionals--Physicians, Dentists, Osteopaths, Optometrists, Pharmacists," Educational Journal, published by the Institute for the Development of Indian Law, Washington, D.C. Vol. 1, No. 10 (June-July, 1973), 13-16.

Colombel, Pierre A. Memorandum "A" to Jack Casebolt, through Director Warren Cardwell, Office of Health Resources. Subject: "Response to the George Clark Memo of December 15, 1972: Manpower Training and Projections."

Desert Willow Training Center, IHS. "The Administrative Officer Training Program--Career Development Program." Tucson, Arizona, August 9, 1973.

Desert Willow Training Center, IHS. "Community Health Worker Task Inventory." Tucson, Arizona.

Desert Willow Training Center, IHS. "Office of Management Training and Field Assistance--Course Announcements." Tucson, Arizona. September-December, 1973.

Desert Willow Training Center, IHS. "Start--Indian Health Service Career Development Proposal." Tucson, Arizona.

Domingo, Priscilla G. "Evaluation of the Indian Health Service Upward and Horizontal Mobility Program." Tucson, Arizona: ORD, IHS, revised July, 1973.

"DWTC CHR Training Program Including Modified Basic Course, Field Training and Supplementary Training." Revised July 18, 1972.

"Future Uncertain for Health Careers Education," Education Journal, published by Institute for the Development of Indian Law, Washington, D.C. Vol. 1, No. 10, (June-July, 1973), 17-19.

IHS. "Resume of IHS Physician Recruitment and Retention Efforts." October 26, 1972.

IHS. "Resume of IHS Physician Recruitment and Retention Efforts." October 26, 1974

IHS. "Summary of Indian Health Service Recruitment and Retention Efforts." November 9, 1972.

U.S. Commission on Civil Rights. Transcript of Proceedings, Phoenix, Arizona, November 17-18, 1972. Washington, D.C.: Ace Federal Reporters, Inc., Official Reporters.

0247

Office of Health Resources, Division of Resource Coordination, IHS. "Collaborative Training Activities of the Indian Health Service." February 14, 1973.

Office of Management Training and Field Assistance, Desert Willow Training Center, IHS, ORD, DHEW. Recommendations of the Indian Health Service. Tucson, Arizona: ORD, DHEW, 1973.

Office of Research and Development, IHS. "Community Health Medic of the Indian Health Service--Progress Report as of January, 1973."

Office of the Solicitor, Department of the Interior. Memorandum to Commissioner, BIA. Subject: "Indian preference employment provision included in construction contracts." June 15, 1955.

Portland Area IHS. "Service Unit EEO Programs--Review and Evaluation."

Portland Area Office, IHS. "Affirmative Action Plan for Equal Employment Opportunity F.Y. 1974--Effective Date March 31, 1974." Portland, Oregon.

Scott, Austin. "Draft's End Perils Supply of Doctors to Treat Indians," The Washington Post, November 21, 1973, p. A8.

Sprinkle, H.D., PhD. "A Proposal for Estimating Technical and Resource Requirements for Implementing MOST." Tucson, Arizona: Office of Research and Development, IHS, July 14, 1972.

Tucson Program Area. "Tucson Program Area Revised Upward Mobility Training Plan." Tucson, Arizona. January 19, 1973.

V. ALCOHOLISM AND MENTAL HEALTH

A. ALCOHOLISM

Alaska Native Health Board. "Evaluation of Alcoholism Treatment Services in the State of Alaska." Done under Contract No. HSM 76-72-328. 1973.

"Indian Alcohol--Chemawa Indian School--Alcohol Abuse Prevention." Grant Application.

Indian Health Service Task Force on Alcoholism, IHS, HSMHA, USDHEW. Alcoholism: A High Priority Health Problem. Publication No. (HSM) 73-12002. 1972.

LaBuff, Stephen. "Chemawa Alcoholism Education Program Proposal to Division of Research Grants National Institutes of Health--Bethesda, Maryland." Continuation of HSM 42-71-55. Oregon: Chemawa Alcoholism Education Program, February, 1972.

Shore, James H., M.D. and von Fumetti, Billee, R.N., M.P.H. "Three Alcohol Programs for American Indians," Amer. J. Psychiat., 28:11 (May, 1972), 1450-1454.

B. MENTAL HEALTH

Aberdeen Area IHS. "Suicide and Suicide Gestures." July, 1972.

Barstow, M.C., Jr., Director, Office for Research Contracts. "Service Networks and Utilization Patterns--Mental Health Programs--IHS--HSMHA." Request for contract submitted by President and Fellows of Harvard College, Department of Behavioral Sciences, Harvard School of Public Health, 1973.

Baster, James T., M.D., Sacramento Medical Center. "Historical and Contemporary Patterns of Northern Cheyenne Suicide." May 1970.

Burnap, Donald W., M.D., Aberdeen Area Indian Health Service. "Suicide and Suicide Gestures." July, 1972.

"Current Status of IHS Mental Program." February, 1971.

Hammebschlag, Carl A., M.D., et al. "Indian Education: A Human System Analysis."

Helper, Malcolm M. and Garfield, Sol L. "Use of the Semantic Differential to Study Acculturation in American Indian Adolescents," JPSP, Vol. 2, No. 6 (1968), 817-822.

HSMHA, PHS, NIH. "Directory of Community Mental Health Centers, Federal Grants for Construction or Staffing."

Levy, Jerrold E., Associate Professor of Anthropology at Portland State University. "Indian Healing Arts." May 30, 1972.

"Mental Health Activities in the Indian Health Program, HEW, PHS, DIH." January, 1968.

NIMH. "Mental Health Services for American Indians and Alaska Natives."

Ogden, Michael, M.D., M.P.H., Spector, Mozart I., B.A., and Hill, Charles A., Jr., M.A.S. "Suicides and Homicides among Indians," Public Health Reports, Vol. 85, No. 1 (January, 1970), 75-80.

"Psychiatric Epidemiology of an Indian Village," Psychiatry Journal for the Study of Interpersonal Processes (February, 1973).

Shore, James H., M.D., Chief, Mental Health Office, Portland Area Indian Health Service. "American Indian Suicide--Fact and Fantasy."

Shore, James H., M.D., Chief, Mental Health Office, Portland Area IHS. "An Integrated Data System for Indian Mental Health." December 12, 1972.

Shore, James H., M.D., Chief, Mental Health Office, Portland Area IHS. "Suicide and Suicide Attempts among American Indians of the Pacific Northwest."

Shore, James A., M.D., et al. "Suicide Prevention Center on an Indian Reservation."

VI. HEALTH MAINTENANCE ORGANIZATIONS AND NATIONAL HEALTH INSURANCE

A. HMO's

Burke, Richard T. "Guidelines for HMO Marketing." Minneapolis: Interstudy, 1973.

Carey, Sarah C., Mazo, Judith F., Meyerson, Bruce, and Edelman, Toby, Lawyers' Committee for Civil Rights under Law. "Health Maintenance Organizations--An Introduction and Survey of Recent Developments." Washington, D.C., October, 1972.

Carson, David C., Group Health Cooperative of Puget Sound. "Satellite HMO--Development of a Prepaid Group Medical Practice in a Small City." Seattle, Washington, August, 1972.

Graduate Program in Hospital Administration and Center for Health Administration Studies, Graduate School of Business, University of Chicago. "Proceedings of the 13th Annual Symposium on Hospital Affairs, May, 1971--Health Maintenance Organizations: A Reconfiguration of the Health Services System." Chicago: Graduate Program in Hospital Administration of the University of Chicago, 1971.

Guntzig, Leon, Ph.D., and Shouldice, Robert G., Research Division, Department of Health Care Administration, School of Government and Business Administration, George Washington University. "Prepaid Group Practice: An Analysis as a Delivery System." Washington, D.C., 1972.

Office of Organizational Development, Bureau of Community Health Services, Health Services Administration, USDHEW. "Selected Annotated Bibliography on Health Maintenance Organizations (HMO's) and Organized Health Care Systems." Washington, D.C.: Government Printing Office, August, 1973.

Somers, Anne R., Editor. The Kaiser Permanente Medical Care Program--A Symposium. Held in Oakland, California, March, 1971. New York: The Commonwealth Fund, 1971.

U.S. Congress. Senate. Senate Report No. 93-129, Calendar No. 120, "Report of the Committee on Labor and Public Welfare together with Minority Views on S. 14." 93rd Congress, 1st session, April 27, 1973.

B. NATIONAL HEALTH INSURANCE

Committee for National Health Insurance. "The Health Security Program 1973." Washington, D.C., 1973.

Congressional Record. Material re Long-Ribicoff Bill (S. 2513)--Catastrophic Health Insurance and Medical Assistance Reform Act of 1973. Vol. 119, Nos. 146, 164, 179, October 2, 20, 30, 1973. 93rd Congress, 1st session.

Iglehart, John K. "HEW Health Insurance Plan," National Journal Reports, Vol. 5, No. 42 (October 20, 1973), 1570-1571. Washington, D.C.: Government Research Corporation.

Iglehart, John K. "National Health Insurance," National Journal Reports, Vol. 5, No. 50 (December 15, 1973), 1855-1863. Washington, D.C.: Government Research Corporation.

Indian Health Service. National Health Insurance Task Force (Indian Health Service Reply to Specific Questions). Rockville, Maryland, September 29, 1972.

"Kennedy and Labor Take Another Look at Health Security Bill," "Nixon Meets with Aides and Organizations on NHI Plans," Washington Report on Medicine and Health, No. 1381 (December 17, 1973), 1, 2.

Ribicoff, Abe and Long, Russell. Fact Sheet on Long-Ribicoff Catasrophic Health Insurance and Medical Assistance Reform Act of 1973. Washington, D.C., October 2, 1973.

VII. STATISTICAL INFORMATION

Department of Research and Statistics, Health Insurance Plan of Greater New York. H.I.P. Statistical Report. N.Y.C.: Health Insurance Plan of Greater New York, 1972.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. Annual Statistical Review--Hospital and Medical Services, Fiscal Year 1967, "Public Health Service Indian and Alaska Native Hospitals--Contract Hospitals--Field Health." December, 1967.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. Annual Statistical Review--Hospital and Medical Services Fiscal Year, 1968," Illness among Indians and Alaska Natives Calendar Year 1967." March, 1969.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. Annual Statistical Review--Hospital and Medical Services for American Indians and Alaska Natives--Fiscal Year 1969. February, 1970.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. "Discharge Summary and Analysis--Fiscal Years 1962 and 1963." Washington, D.C. January, 1965.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. "Illness among Indians, 1965-1969." DHEW Publ. No. (HSM) 72-507, July, 1971.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. "Indian Health Trends and Services--1969 Edition." Washington, D.C.: Government Printing Office.

Program Analysis and Statistics Branch, Office of Program Planning and Evaluation, IHS. "Indian Health Trends and Services--1970 Edition." PHS Publ. No. 2092.

VIII. IHS STAFF RESEARCH PAPERS

Berg, Lawrence E., Nutting, Paul A., M.D., and Shorr, Gregory I., M.D. "Formulation of an Operating Construct for the Utilization of Skills for Health." Discussion Draft. Tucson, Arizona: Office of Research and Development, IHS, April 23, 1972.

Bozof, Richard P. "Some Navajo Attitudes Toward Available Health Care," AJPH, Vol. 62, No. 12 (December, 1972), 1620-1624.

Crockett, David C., Office of Program Planning and Evaluation, IHS. "Medicine Among the American Indians." May, 1971.

deMontigny, Lionel H., M.D., IHS. "Attitude of Low Expectancy." Portland, Oregon.

deMontigny, Lionel H., M.D., IHS. "Federal Budget Process."

Foster, Ashley, Chief, Office of Program Planning and Evaluation, Portland Area Office, Portland Area Indian Health Service. "A Study of Attitudes Towards Health and Preventive Health Care." Portland, Oregon, January, 1972.

Health Program Systems Center, IHS, Tucson, Arizona. "A Computerized Projected Analysis of the Indian Health Service Family Planning Program." Washington, D.C.: Government Printing Office, October, 1968.

Health Program Systems Center, IHS, Tucson, Arizona. "An Analysis of the Clinic Bus System of the Sells Service Unit." September, 1968.

Health Program Systems Center, IHS, Tucson, Arizona. "Application of the Social Compass to the Study of Health." September, 1968.

Health Program Systems Center, IHS, Tucson, Arizona. "Health Concepts and Attitudes of the Papago Indians." September, 1968.

Health Program Systems Center, IHS, Tucson, Arizona. "Health Program Evaluation" Impact Study of the Indian Sanitation Facilities Construction Act." 1972.

"Infant Gastroenteritis--A Developmental Component of Project Focus," Interim Report, July 1, 1972 - September 15, 1972. Prepared for Executive Health Staff of the Papago Tribe and Office of Research and Development, IHS. September 22, 1972.

Nutting, Paul A., M.D. and Shorr, Gregory I., M.D. "Minor Acute Problems of the School Age Child--An Application of the Problem Solving Process."

Nutting, Paul A., M.D., Shorr, Gregory I., M.D., and Berg, Lawrence E. "Standards of Care and Task Inventory--Maternal and Child Health Conception through Infancy." Developed for the Sells Service Unit. Tucson, Arizona: Office of Research and Development, IHS, October, 1973.

Sheckleton, G.F., Branch Chief, Billings, Montana. "Memorandum of Agreement." Draft Copy. March 25, 1973.

Sheckleton, G.F., Branch Chief, Billings, Montana. "Strategic Issues Relating to IHS Resource Allocation." Draft Copy. May 15, 1973.

Shorr, Gregory I., M.D., Office of Research and Development, Tucson, Arizona, IHS. "Sells Emcro: Quarterly Report." October 1, 1973.

Wagner, Carruth J. and Rabeau, Erwin S. "Indian Poverty and Indian Health," Health, Education, and Welfare Indicators (March 1964), xxiv-xliii. Washington, D.C.: Government Printing Office.

White River Service Unit of IHS. "Family Physician Project." Prepared for presentation to the Eighth Joint Meeting of the Professional Associations of the U.S. Public Health Service, May 9-12, 1973, Phoenix, Arizona.

IX. HEALTH SERVICES TO INDIANS NOT LIVING ON RESERVATIONS

"Availability of Health Services to Phoenix Urban Indians," The Concerned Indians, Vol. 3, No. 4 (March, 1972), 1-2. Phoenix: Amerind of Phoenix, Inc.

Billings American Indian Council, Inc. "Proposal--Urban Indian Health Project." Billings, Montana.

California Rural Indian Health Board--Project News (Winter 1971/72) Berkeley, California.

California Urban Indian Health Council, Inc. "Articles of Incorporation of the California Urban Indian Health Council, Inc."

California Urban Indian Health Council, Inc. "By-Laws of the California Urban Indian Health Council, Inc." 1972.

California Urban Indian Health Council. List of Members.

Cottier, Belva, Chairman of California Urban Indian Health Council, San Francisco, California. Letter to William H. Donner Foundation, Inc., August 30, 1972. Enclosures:

a. Resolution of California Urban Indian Health Council

b. Proposal for Organization Funding for the California Indian Health Council (CUIHC), submitted to Donner Foundation, N.Y., N.Y.

Mito, Bob and Sata, L.S., M.D. "The Dilemma of Urban Indian Health."

Sclar, Lee J. "Participation of Off-Reservation Indians in Programs of the Bureau of Indian Affairs and the Indian Health Service," Montana Law Review, Vol. 33, No. 2 (Summer 1972), 191-232.

Seattle Indian Health Board, Inc. "Health Needs and Demands of Seattle Area Indians. A Preliminary Analysis of Data Collected in the Seattle Indian Board Medical Clinic." Seattle, Washington, November, 1973.

Sullivan, Robert, M.D. "North Dakota Off-Reservation Indian Health Study." Bismarck, North Dakota: Division of Health Planning, October, 1972.

X. GENERAL INDIAN HEALTH

American Hospital Association. Letter to Members of House of Delegates, Illinois. Subject: "Patient's Bill of Rights." Enclosures:
a. Patient's Bill of Rights, approved by Board of Trustees, August 8, 1972, affirmed as revised by Board of Trustees, November 17, 1972.
b. Chronology of Development of Patient's Bill of Rights.

Anderson, Jack. "Epidemics among Indians Feared," The Washington Post, January 4, 1974, p. D15.

"Association of State and Territorial Health Officers Committee on Indian Health." Record of the meeting of the Navajo Area Indian Health Service held at Window Rock, Arizona, September 27-28, 1971.

Barow, Mark V., Niswander, Jerry D., Fortuine, Robert. Health and Disease of American Indians North of Mexico--A Bibliography, 1800-1969. Gainesville, Florida: University of Florida Press, 1972.

Butler, Gordon C., M.D. "Delivery of Health Care in Northern Canada." Canadian Journal of Opthalmology, Vol. 8, No. 2 (April, 1973), 188-195.

"The Case of Mary Grey-Eyes," Time, November 10, 1958.

College Alaska, HSMHA, HEW. "Impact of the Land Claims Settlement on Alaska Native Health." 1971.

DIH, PHS, USDHEW. "Meeting of the Surgeon General's Advisory Committee on Indian Health." Held in Tucson, Arizona November 8-11, 1967.

"Fourth National Conference on Indian Health," Arch. Environ. Health, Vol. 19 (September, 1969).

"HEW Sets High Priority on Indian Affairs," HEW Newsletter (December 21, 1973), 6.

IHS, HSMHA, USDHEW. Conference Record--Indian Health Committee of the American Academy of Family Physicians. Gallup Indian Medical Center, Gallup, New Mexico, September 13-14, 1971.

Kane, Robert, M.D. and Kane, Rosalie, MSW. "Determination of Health Care Expectations among Navajo Consumers: Consumers in a Federal Care System," Medical Care, Vol. X, No. 5 (September-October, 1972), 421-429.

Kane, Robert L. and Kane, Rosalie A. Federal Health Care (With Reservations!). New York: Springer Publishing Co., Inc., 1972.

Leigh, Robert D. "National Medical Care of the Indians," Federal Health Administration in the United States, 1925.

"Medical Services, Department of National Health and Welfare, 1967." Ottawa: Information Canada, 1970.

Merian and Associates. "Health, the Problem of Indian Administration," 1928.

Mountin and Townsend, USPHS, USDHEW. "Observations on Indian Health Problems and Facilities."

OSG, PHS, USDHEW. "Health Services for American Indians." March 11, 1957.

Shaw, M.D., Division of Public Health Methods, USPHS. "The Indian Health Program from 1800-1955." March 11, 1959.

XI. FORMS

"Ambulatory Patient Care Report." Blank Form.

"Daily Service Report of Community Health Activities." Blank Form.

"Negotiated Contract for CHS Hospital and Physician." Blank Form

"Negotiated Contract for Medical, Dental, Nursing, or Paramedical Services." Blank Form.

O'Dea, Antone F., Contracting Officer, Billings Area IHS, HSMHA, PHS, DHEW. Contract No. HSM-85-74-61, covering hospital services to authorized Indians of the IHS. June 29, 1973.

O'Dea, Antone F., Contracting Officer, Billings Area IHS, HSMHA, PHS, DHEW. Contract No. HSM-85-74-21, covering medical services to authorized Indians of IHS. June 29, 1973.

Portland Area IHS. "Service Unit EEO Program--Review and Evaluation." Blank Form.

"Service Unit Director Standards of Performance." Blank Form.

"Social Service and Mental Health Report." Blank Form.

XII. GENERAL

A Program for Indian Citizens, A Summary Report, January, 1961.

Belindo, J., Jones, M., Sahamaunt, H., Hallett, W. et. al. "Project Outreach--An Assessment of Tribal Attitudes and Appraisal of the Extent of Tribal Council Experience in Administering Federal Assistance Programs." Reports and discussion at meeting in Gaithersburg, Maryland, April 29, 1970. Prepared for the National Council on Indian Opportunity, Office of the Vice President, Washington, D.C.

"Health Crisis in America, A Report by the American Public Health Association, N.Y."

"Indian American Issues, A Handbook for Discussion," NCP Publication.

Mackey, John and Blanchard, Evelyn. "The American Indian," Ethnic Differences Series No. 1. Washington, D.C.: National Rehabilitation Association.

Report of the Committee on Indian Affairs to the U.S. Commission on Organization of the Executive Branch of the Government, Committee on Indian Affairs, October 1968 (Selected Portions).

Stevens, E.L., Jollie, J., MacNabb, A.S. et al. "Indian Eligibility for Bureau Services--A Look at Tribal Recognition and Individual Rights to Services."

Taylor, Theodore W. The States and their Indian Citizens. 1972.

U.S. Congress. Senate. S.J. Res. 133 introduced by Sen. Abourezk. 93rd Congress, 1st session, July 16, 1973.